Arizona Medical Board

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FINAL MINUTES FOR REGULAR SESSION MEETING
Held at 9:30 a.m. on December 6, 2006 and 8:00 a.m. on December 7, 2006, 9535 E. Doubletree Ranch Road · Scottsdale, Arizona

Board Members

Robert P. Goldfarb, M.D., F.A.C.S., Chair
William R. Martin III, M.D., Vice Chair
Douglas D. Lee, M.D., Secretary
Patrick N. Connell, M.D.
Patricia Griffen
Tim. B. Hunter, M.D.
Becky Jordan
Ram R. Krishna, M.D.
Lorraine L. Mackstaller, M.D.
Sharon B. Megdal, Ph.D.
Dona Pardo, Ph.D., R.N.
Paul M. Petelin Sr., M.D.

Executive Director's Report
Executive Director and Agency Office Reports

For the past year, the Investigative Office has continued to maintain their 180 day average for completing cases. Due to the efficiency of the investigations process, the Arizona Medical Board will be going into the next year with approximately 700 fewer cases than what the agency had when going into 2006. The agency will begin 2007 with only 380 open investigations.

The Licensing Office experienced about a 21% increase in applications over the previous year with 1,440 applications processed in 2006. The licensing staff has improved the timeframe for processing applications and during the months of September and October 2006 it took an average of 19 days from the time of receipt of the application until it was processed, for routine applications not requiring investigation.

The agency is continuing to work with the selected vendor in developing the new database. The new database is a web-based database that will be more user-friendly and easy to navigate through.

In February of 2007 the Arizona Medical Board will hold its election of officers and nominations may be submitted to the Executive Director immediately so the ballot can be created.

The Board then recognized Chris Banys, Physician Health Program Assistant Manager for her five years of service with the Arizona Medical Board. The Board recognized the great asset Ms. Banys had been to the agency and presented her with a plaque for her service and dedication to the Arizona Medical Board. Timothy C. Miller, J.D., Executive Director expressed his gratitude for Ms. Banys's service and noted the Board's Monitored Aftercare Program (MAP) contract was in good hands with Ms. Banys carrying on the monitoring for the Board's MAP vendor, Greenberg & Sucher, PC. The Board expressed their confidence that Ms. Banys would be an asset in her new position with the office of Greenberg & Sucher, PC and wished her well in her new endeavor.

Chair's Report
Robert P. Goldfarb, M.D. recognized Tim B. Hunter, M.D. for his nine years of service on the Arizona Medical Board from 1997 to 2006 and presented him with a plaque. Dr. Goldfarb thanked Dr. Hunter on behalf of the Board for his contributions and diligence in serving and expressed that the Board would miss his input.

Legal Advisor Report
Christine Cassetta, Board Legal Counsel provided the Board with her Quarterly Report for July 1, 2006 through September 30, 2006. The Board reviewed the materials but did not engage in discussion.

Litigator Report

Dean Brekke, Assistant Attorney General updated the Board on the Superior Court Decisions regarding Hara P. Misra, M.D. and Deborah S. Golob, M.D. Robert P. Goldfarb, M.D. thanked Mr. Brekke and the other litigators for their hard work in processing cases the Board refers to the Office of Administrative Hearings.

Consideration of Substantive Policy Statement re: Internet Prescribing

The Internet Prescribing Subcommittee met several times to develop the Substantive Policy Statement and to hear input from the community. The Substantive Policy Statement (SPS) as drafted establishes the minimum standard of care for treating patients. Secondly, the SPS defines prescribing doctor/ patient relationships. Thirdly, the SPS identifies problems with internet prescribing, and as a fourth point, distinguishes the difference between telemedicine and e-scripts. The SPS concludes that, prior to prescribing a physician must obtain a reliable medical patient history.

Sharon B. Megdal, Ph.D. suggested the concluding summary paragraph of the SPS be copied to be the first paragraph of the document as well so the document can be more clearly understood. Douglas D. Lee, M.D. provided an editorial correction and Dona Pardo, Ph.D., R.N. asked if the Board wanted to change the foot note on page one say "registered nurse" rather than just "nurse" alone, to be more definitive. Dr. Lee noted a Licensed Nurse Practitioner (LPN) can do parts of an examination and the wording in the footnote that states "licensed person within their scope" should be adequate clarification.

MOTION: Tim B. Hunter, M.D. moved to accept the Substantive Policy Statement regarding Internet Prescribing.
SECONDED: Patricia R.J. Griffen
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

Tim B. Hunter, M.D. commended the Board by saying that the state of Arizona is one of the leaders in developing a Policy Statement for Internet Prescribing and, despite vigorous attacks for their position, has accomplished an exemplary policy.

Proposed Sunrise Legislation – Non Physician Surgical Assistants

Terri Aldama, RN, CRNFA from the Association of Operating Room Nurses (AORN) and State representative AORN's legislative committee, spoke during Call to Public and asked the Board not to support licensure of non physician surgical assistants under the regulatory jurisdiction of the Arizona Medical Board. Ms. Aldama said AORN was in support of certification or registration for non physician surgical assistants under nursing.

Timothy Miller, J.D., Executive Director said the proposed Sunrise Legislation has language that suggests the Arizona Medical Board would regulate non-physician surgical assistants through licensure, even though they language uses the term "certification". William R. Martin, III, M.D. noted this subject is a contentious issue. Mr. Miller recommended the Board not take a position either way on the matter because the bill language was not complete. Mr. Miller said this bill raised some concerns about public health and safety and also about the Arizona Medical Board's current fee structure to support additional regulation.

Consideration of Prescription Monitoring Program

Robert P. Goldfarb, M.D. noted the new Prescription Monitoring Program would create a downside for physicians as there would be a fee and additional regulation imposed because of a prescribing permit that would be issued by Pharmacy Board. Dr. Hunter noted a prescribing permit would have to be obtained to write a prescription for just one controlled substance and this would put an undue burden on physicians who do not prescribe controlled substances often. Dr. Hunter noted the Board would receive numerous complaints for physicians who were not aware they had to obtain a permit for medications for which they had been writing prescriptions all along. Robert P. Goldfarb, M.D. noted, although the proposed fee for the permit was nominal, it would continue to grow through the years. Ram R. Krishna, M.D. opined that the Prescription Monitoring Program would not be an asset to the safety of the public.

MOTION: Tim B. Hunter, M.D. moved to oppose the Prescription Monitoring Program in its current form.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

Becky Jordan said she opposed the Prescription Monitoring Program as it would allow any person with a permit access to patient medical information regardless of whether they treated the patient or not and felt this was an undue intrusion into patient privacy.

Appointment of Members to Subcommittee on Physician Assistant Supervision

Robert P. Goldfarb, M.D. appointed the following Board Members to the Subcommittee on Physician Assistant Supervision: Becky Jordan, Patrick N. Connell, M.D., Ram R. Krishna, M.D., Paul M. Petelin, Sr., M.D. and Robert P. Goldfarb, M.D.

Dr. Goldfarb asked Staff to arrange a teleconference for the Subcommittee so that there could be a discussion with the Board by the time of the February 2007 Arizona Medical Board Meeting.

Approval of Minutes

MOTION: Lorraine Mackstaller, M.D. moved to approve the October 11-12, 2006 Regular Session Meeting Minutes, including Executive Session Minutes.
SECONDED: Douglas D. Lee, M.D.

VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

MOTION: Paul M. Petelin, Sr., M.D. moved to approve the November 3, 2006 Meeting Minutes, including Executive Session Minutes.
SECONDED: Patricia R.J. Griffen
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

REVIEW OF ED DISMISSALS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0244A	C.R.	BRIAN D. ESPINOZA, M.D.	25475	Uphold ED dismissal
2.	MD-06-0014B	V.C.	KARUKURICHI S. VENKATESH, M.D.	9783	Uphold ED dismissal
3.	MD-06-0073A	A.S.	GILLES J. LACHANCE, M.D.	31601	Uphold ED dismissal
4.	MD-06-0374A	J.H.	BRIAN H. PERLMUTTER, M.D.	27305	Uphold ED dismissal

Christine Cassetta, Board Legal Counsel explained this complaint was not a repetitive allegation and did not relate to Dr. Perlmutter's case on the same agenda under the Advisory Letter section.

MOTION: Sharon B. Megdal, Ph.D. moved to uphold ED dismissal the case.
SECONDED: Douglas D. Lee, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-06-0257A	B.L.	LARRY C. LEVERETT, M.D.	19168	Uphold ED dismissal

BL was present and spoke during the call to the public. BL said she paid Dr. Leverett to perform a nose surgery and lip roll but he did not perform the surgery to her satisfaction and treated her unprofessionally when she expressed her dissatisfaction. BL said Dr. Leverett's office staff said he would cover the cost of her to have the procedure re-done with another physician. However, Dr. Leverett did not pay for the corrective procedure as promised.

William R. Martin, III, M.D. said he knows Dr. Leverett but it would not affect his ability to adjudicate the case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-05-0518A	J.H.	GERALD B. WALMAN, M.D.	10481	Uphold ED dismissal
7.	MD-05-0659A	R.F.	DANIEL P. MCCABE, M.D.	27455	Uphold ED dismissal

Tammy Johnson the patient's daughter was present and spoke during the call to the public. Ms. Johnson said the Arizona Medical Board did not interview her before recommending dismissal. Ms. Johnson said Dr. McCabe told the family, following RF's surgery, that he was not able to distinguish the difference between RF's necrotic tissue and her kidney and he admitted he injured RF's kidney during the procedure. Robert Fellker, the patient's husband was also present and spoke during the call to the public stating Dr. McCabe admitted mistake his mistake in this case and should be held accountable.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-06-0137A	L.F.	J. GAVIN GONZALEZ, M.D.	26245	Uphold ED dismissal

LF was present and spoke during the call to the public. LF said he presented to Dr. Gonzalez for tonsillitis and made it clear he did not have a problem with sleep apnea and did not want to be treated for such. However, LF said Dr. Gonzalez proceeded to remove his uvula and soft palate which was a procedure that would be completed for someone with sleep apnea.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-06-0436A	S.H.	TAMMY R. KOPELMAN, M.D.	31135	Uphold ED dismissal
10.	MD-05-1102A	O.J.	JAMES A. HIATT, M.D.	32626	Uphold ED dismissal

James Hiatt, M.D. was present and spoke during the call to the public. Dr. Hiatt said he is a caring physician and does his best for each patient. Dr. Hiatt said he reviewed this case with several physicians who agreed they would have dealt with the complication of the procedure in the same way that he did. Dr. Hiatt explained the complication was a known complication for the procedure and can occur no matter how well the procedure is performed. Dr. Hiatt said he wanted the patient to know he was sorry the complication occurred.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-06-0054A	S.B.	ANYALYNN D. NEWSON, M.D.	21621	Uphold ED dismissal
12.	MD-06-0362A	M.H.	HECTOR A. SALAZAR, M.D.	22596	Uphold ED dismissal
13.	MD-06-0263A	K.M.	WALDECK CHARLES, M.D.	33521	Uphold ED dismissal

KM was present and spoke during the call to the public. KM said his family needs guardianship of the patient for supervision of his anti-psychotic medication. However, Dr. Charles refused to help his family get the necessary guardianship of the patient to protect him from harm.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
14.	MD-06-0222A	E.D.	DENNIS L. KILPATRICK, M.D.	13541	Uphold ED dismissal
15.	MD-06-0228A	W.J.	ALICIA K. GUICE, M.D.	28062	Uphold ED dismissal
16.	MD-06-0476A	C.K.	ERICK R. MARTINEZ, M.D.	20874	Uphold ED dismissal
17.	MD-06-0312A	S.E.	KIAN J. SAMIMI, M.D.	25504	Uphold ED dismissal
18.	MD-06-0297B	H.A.	GALEN B. JOHNSON, M.D.	19218	Uphold ED dismissal

HA was present and spoke during the call to the public. HA alleged Dr. Johnson injured her son during delivery and because of such her son now has multiple disabilities and is dependent on others for constant care. HA also said Dr. Johnson altered her medical records by fabricating some of the statements related to the labor and delivery process.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
19.	MD-06-0437A	J.B.	ERIC S. BERENS, M.D.	20512	Uphold ED dismissal

Robert P. Goldfarb, M.D., Lorraine Mackstaller, M.D. and Sharon B. Megdal, Ph.D. recused themselves on this case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
20.	MD-06-0360A	N.R.	PAUL F. GREGORY, M.D.	14113	Uphold ED dismissal
21.	MD-06-0360B	N.R.	STEVEN P. EMMONS, M.D.	31951	Uphold ED dismissal
22.	MD-06-0360D	N.R.	NICHOLAS METZGER, M.D.	25764	Uphold ED dismissal

MOTION: Becky Jordan moved to uphold the Executive Director dismissal of items 1- 3, and 5- 22.
SECONDED: William R. Martin, III, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

ADVISORY LETTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0407A	M.H.	BRIAN B. BRUGGEMAN, M.D.	31346	Advisory Letter for inadequate examination and diagnosis.

Douglas D. Lee, M.D. recused himself from this case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-05-0902B	AMB	BRIAN H. PERLMUTTER, M.D.	27305	Advisory Letter for failure to recognize torn chordae tendinae.

Jill Herman was present and spoke during the call to the public. Ms. Herman said Dr. Perlmutter failed to report a significant clinical finding that he saw in the patient's Transesophageal Echocardiogram (TEE) because it slipped his mind. Ms. Herman said Dr. Perlmutter also failed to actively exclude a cardiac cause and get blood cultures for the patient. Ms. Herman said Dr. Perlmutter admitted he fell below the standard of care in this case. Ms. Herman said Dr. Perlmutter admitted he was abusing substances during that period of time although it can not be proven he was under the influence during this particular case.

Mark Nanney, M.D., Chief Medical Consultant said Dr. Perlmutter's only involvement in this case was reading the TEE and the Outside Medical Consultant reviewed the TEE and said there was no vegetation, just a ruptured chordae tendinae that was not mentioned in his report. Dr. Perlmutter conceded he did not mention the ruptured chordae tendinae.

MOTION: Lorraine Mackstaller, M.D. moved to issue an Advisory Letter for failure to recognize torn chordae tendinae.
SECONDED: Becky Jordan
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-06-0203A	E.C.	FELIX F. JABCZENSKI, M.D.	23092	Advisory Letter for failing to perform a proper history and physical.

Tim B. Hunter, M.D. recused himself from the case.

EC was present and spoke during the call to the public. EC said Dr. Jabczenski took x-rays of the wrong part of her arm and took away her splint without diagnosing a break in the arm. EC said she discovered three days later that she had a broken arm in three places.

Donna Hansen, EC's caregiver, was also present and spoke during the call to the public. Ms. Hansen said EC's arm looked noticeably misaligned and EC could not support herself with it. Ms. Hansen said it should have been obvious to Dr. Jabczenski that EC's arm was broken.

Dr. Krishna noted Dr. Jabczenski's documentation of EC's history and physical appropriately showed he failed to perform a proper history and physical for EC. Dr. Krishna noted EC had severe rheumatoid arthritis and yet his records sated EC was well developed and well nourished, when in fact EC had a dehabilitating disease.

Dr. Krishna noted Dr. Jabczenski took an x-ray of EC's elbow only and it did not show fracture. However, Dr. Krishna noted EC may have only been complaining of elbow pain. Dr. Krishna said that whether or not the fracture was there at the time Dr. Jabczenski saw EC, could not be determined and Dr. Jabczenski could not be faulted for missing a fracture.

MOTION: Ram R. Krishna, M.D. moved to issue an Advisory Letter for failing to perform a proper history and physical.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 8-yay, 0-nay, 0-abstain, 1-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-06-0239A	B.B.	ELLEN S. SCHAEFFER, M.D.	34518	Advisory Letter for inadequate medical records.

Ellen Schaeffer, M.D. was present and spoke during the call to the public. Dr. Schaeffer said she went through the risks and benefits of the procedure with the patient prior to performing the procedure. Dr. Schaeffer said the procedure was indicated and went smoothly.

Scott Holden, legal counsel for Dr. Schaeffer was present and spoke during the call to the public. Mr. Holden said the Staff Investigational Review Committee stated the removal of the hemorrhoid was not an emergency room procedure, however, Mr. Holden read literature to the Board to show the procedure was performed in the correct setting.

William Wolf, M.D., Medical Consultant said, in his opinion, Dr. Schaeffer met the standard of care in this case. Dr. Wolf said there was no documentation on Dr. Schaeffer's part of how the procedure was performed, however, there were nursing notes documenting the procedure.

Mark Nanney, M.D., Chief Medical Consultant said he found Dr. Schaeffer did not meet the standard in the removal of the patient's hemorrhoid because the patient required a second surgery for the hemorrhoid. Dona Pardo, Ph.D., R.N. said she found Dr. Schaeffer's medical records were inadequate.

MOTION: Douglas D. Lee, M.D. moved to issue an Advisory Letter for inadequate medical records.
SECONDED: Ram R. Krishna, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-05-1173A	AMB	ELLEN S. SCHAEFFER, M.D.	34518	Advisory Letter for inadequate medical records with 10 hours of CME in record keeping.

Ellen Schaeffer, M.D. was present and spoke during the call to the public. Dr. Schaeffer said her first priority in this case was to save the child's life and that involved getting the child transported to the next hospital. Dr. Schaeffer said, due to the urgency of the situation, she was not able to make the documentation in the medical record more detailed because she did not want to hold up transport for even a few minutes. However, she noted the medical record was fairly detailed despite the situation. Dr. Schaeffer said, most importantly, the patient had good outcome in this case.

Scott Holden legal counsel for Dr. Schaeffer was present and spoke during the call to the public. Mr. Holden said the standard of care relates to what is reasonable under the circumstances. Mr. Holden said the circumstances in this case did not allow Dr. Schaeffer to have a more thorough medical record and she relied on the nurse's documentation as well as her own in this situation.

William Wolf, M.D., Medical Consultant summarized the case for the Board and stated Dr. Schaeffer was busy with the emergent care of the patient and because of such, her suboptimal charting was acceptable due to the circumstances.

MOTION: Becky Jordan moved to Dismiss the case.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 3-yay, 6-nay, 0-abstain, 0-recuse, 3-absent
MOTION FAILED.

Dona Pardo, Ph.D., R.N. said Dr. Schaeffer could have documented the events of the case as an addendum at a later time. Dr. Pardo said an Advisory Letter should not be issued twice for similar cases for the same physician. Dr. Pardo said the inadequate medical records in this case should have elevated the action because it reoccurred. Douglas D. Lee, M.D. spoke against the motion stating Dr. Schaeffer should have at least called the hospital the patient was transferred to, since the medical record was incomplete. Dr. Lee suggested non-disciplinary Continuing Medical Education (CME) in record keeping. Robert P. Goldfarb, M.D. said Dr. Schaeffer did speak to the hospital where the patient was transferred and did everything appropriately; therefore, issuing non-disciplinary CME would be too harsh of an Order in this case.

MOTION: Douglas D. Lee, M.D. moved to issue an Advisory Letter for inadequate medical records with 10 hours of CME in record keeping.
SECONDED: Ram R. Krishna, M.D.
VOTE: 6-yay, 3-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-06-0109A	AMB	BARBARA J. MERZ, M.D.	21603	Advisory Letter for failure to timely recognize complication of surgery.

Robert P. Goldfarb, M.D. noted Dr. Merz failed to recognize bowel perforation and failed to diagnose sepsis in a timely fashion resulting in the patient's death. Dr. Goldfarb said this case warranted more than an Advisory Letter.

William Wolf, M.D., Medical Consultant noted there were mitigating factors in the case: the patient's abdominal exam was equivocal, the patient's presentation appeared to be a rectus hematoma, and Dr. Merz struggled with her decision to operate in this case. Dr. Wolf noted Dr. Merz did perform a Computed Tomography (CT) Scan but it did not clearly demonstrate the presence of an intra-abdominal injury.

Ram R. Krishna, M.D. noted Dr. Merz had considered an abdominal injury but the CT scan was non-conclusive.

MOTION: Ram R. Krishna, M.D. moved to issue an Advisory Letter for failure to timely recognize complication of surgery.
SECONDED: Dona Pardo, Ph.D., R.N.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-06-0264A	AMB	ABDOL R. ARJMANDFARD, M.D.	33227	Advisory Letter for failure to timely attend to a patient in respiratory distress.
8.	MD-06-0352A	A.M.	KIRK A. BUCON, M.D.	16151	Advisory Letter for failure to recognize mass on CT scan.

Becky Jordan pulled this case for discussion and noted Dr. Bucon failed to recognize an aggressive tumor on a CT scan.

William Wolf, M.D., Medical Consultant said the Outside Medical Consultant looked at film and said an abnormality was present. Tim B. Hunter, M.D. found it aggravating that the patient asked Dr. Bucon to put an addendum on CT scan report to show a mass was present, and Dr. Bucon refused to do so.

MOTION: Tim B. Hunter, M.D. moved to issue an Advisory Letter for failure to recognize mass on CT scan.
SECONDED: Sharon B. Megdal, Ph.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-06-0350A	AMB	THOMAS J. PETRONE, M.D.	23585	Advisory Letter for failure to properly monitor Lithium resulting in renal failure.
10.	MD-06-0462A	N.G.	PATRICIA L. CLARKE, M.D.	26877	Advisory Letter for failure to appropriately document interaction with patient to support comprehensive history, physical and moderate medical decision making for billing code 99205 with 10 hours non-disciplinary Continuing Medical Education in medical billing codes to be completed within one year.

William R. Martin, III, M.D. recused himself from this case.

Patricia Clark, M.D. was present and spoke during the call to the public. Dr. Clark said she appropriately billed for code 99205 as her counseling of the patient dominated more than 50% of the appointment. Dr. Clark said she spent 92 minutes with the patient and the billing coding textbook states time spent over 60 minutes qualifies for billing code 99205.

Kelly Sems, M.D., Internal Medical Consultant summarized case for the Board. Dr. Sems said Dr. Clarke listed problems but no discussion of the patient's chief complaint. Additionally, Dr. Sems found Dr. Clarke's review of systems was not rigorous.

Robert P. Goldfarb, M.D. found Dr. Clarke's examination did not qualify for billing code 99205 as she did not document a comprehensive physical or decision making process. Dr. Goldfarb noted Dr. Clarke's medical record showed Dr. Clarke spent time on education and counseling, but the records did not show what the patient was counseled or educated on.

MOTION: Ram R. Krishna, M.D. moved to issue an Advisory Letter for failure to appropriately document interaction with patient to support comprehensive history, physical and moderate medical decision making for billing code 99205 with 10 hours non-disciplinary Continuing Medical Education in medical billing codes to be completed within one year.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 8-yay, 0-nay, 0-abstain, 1-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-06-0483A	AMB	THOMAS G. DALLMAN, M.D.	16390	Advisory Letter for not reporting impairment of a physician assistant.
12.	MD-05-0627A	R.K.	EDWARD D. CAMPBELL, M.D.	9515	Advisory Letter for excessive billing and unbundling of medical codes.
13.	MD-06-0230A	AMB	CRAIG E. JOHNSON, M.D.	20661	Advisory Letter to timely diagnose and treat an ectopic pregnancy.

Ingrid Haas, M.D., Medical Consultant summarized the case for the Board. Dr. Haas said Dr. Johnson mistakenly made a diagnosis of a missed abortion instead of missed ectopic pregnancy, in spite of the fact that no sac was discovered in the patient. It was mitigating that patient was non-compliant and if she had come in to see Dr. Johnson earlier, Dr. Johnson may have been able to manage the patient more appropriately.

MOTION: Douglas D. Lee, M.D. moved to issue an Advisory Letter to timely diagnose and treat an ectopic pregnancy.
SECONDED: Ram R. Krishna, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
14.	MD-06-0435A	AMB	ALTON V. HALLUM, M.D.	21585	Advisory Letter for failure to communicate results of a cancer diagnosis.

Sharon B. Megdal, Ph.D. said she knows Dr. Hallum but it would not affect her ability to adjudicate the case.

MOTION: Tim B. Hunter, M.D. moved to issue Advisory Letters for items 1, 7, 9, 11, 12 and 14.
SECONDED: Becky Jordan
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
15.	MD-05-1145A	AMB	ANDREW A. BRAINARD, M.D.	27266	Advisory Letter for failure to diagnose rib fractures.

Jill Covington legal counsel was present and spoke on behalf of Dr. Brainard during call to the public. She stated it is not below the standard of care for an emergency room physician to miss rib fractures on an x-ray. Ms. Covington said it was mitigating that the patient lied to Dr. Brainard about how his injury occurred because he wanted his health care costs to be compensated by his employer. Ms. Covington stated that knowing the mechanism of injury would have raised Dr. Brainard's suspicion to the level of injury.

Dona Pardo, Ph.D., R.N. noted the Outside Medical Consultant said there was no actual harm in the case because rib fractures are often missed. The Board then reviewed the x-rays for the case. Tim B. Hunter, M.D. noted that the rib fractures were fairly clear. Dr. Pardo said it was the standard of care for physicians to recognize the type of fracture as was seen in this case.

MOTION: Ram R. Krishna, M.D. moved to issue an Advisory Letter for failure to diagnose rib fractures.
SECONDED: Tim B. Hunter, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

OTHER BUSINESS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-05-0956A	J.V.	DAVID L. CHILD, M.D.	6275	Consent Agreement for a Letter of Reprimand for removal of ovaries without indication and without informed consent and for failure to inform the patient her ovaries were removed.

JV was present and spoke during the call to the public. She signed a consent form for her surgery and understood she was consenting to only the things listed on the form. When Dr. Child asked her during the surgery if he could do another procedure and she said "no" but he did not honor her wishes and did not inform her he performed the unwanted procedure. JV said the additional surgery was unnecessary and she has

experienced numerous complications as a result of the procedure. JV also said she also had not been able to obtain the records from Dr. Child regarding her medical procedure for the past six months.

Ram R. Krishna, M.D. noted the Consent Agreement for a Letter of Reprimand did not address JV's failure to get medical records. Ms. Cassetta stated Staff would review the complaint to determine if it contained an allegation regarding her inability to obtain her medical records and possibly open a subsequent investigation.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-05-0524A	AMB	WILLIAM R. BURKS, M.D.	18669	Consent Agreement for a Letter of Reprimand for failure to implant the correct intraocular lens in two patients.
3.	MD-05-0625A	AMB	DEEPAK K. SANAN, M.D.	24212	Consent Agreement for a Letter of Reprimand for failing to appropriately assess an asymmetric thyroid gland in a patient with a history of radiation therapy to the gland and for inadequate medical records.
4.	MD-05-1118A	D.L.	SUDHIR K. GOEL, M.D.	27103	Consent Agreement for a Letter of Reprimand for failure to document the severity of the patient's back pain and examinations concerning the assessment of the patient's back pain after several visits and for failure to adequately document subsequent back examinations.
5.	MD-06-0328A	E.C.	FRANC W. BRODAR, M.D.	24079	Consent Agreement for a Letter of Reprimand for inappropriately prescribing for office staff without keeping a medical record and without conducting a physical examination and for prescribing Hydrocodone under another physician's name and diverting it for his own use. 5 year probation with MAP terms.
6.	MD-05-0806A	AMB	C.W. BRYANT, M.D.	20954	Consent Agreement for a Letter of Reprimand for failure to adequately address acute respiratory decompensation and for inadequate medical records.

MOTION: Tim B. Hunter, M.D. moved to Accept Proposed Consent Agreements for items 1-6.
SECONDED: William R. Martin, III, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Members were absent: Patrick N. Connell, M.D. and Patricia R.J. Griffen.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-05-0427A	AMB	GEORGE KAM K. WONG, M.D.	21765	Accept Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to ask appropriate questions and follow up on a critically ill patient.

Christine Cassetta, Board Legal Counsel stated that Dr. Wong's attorney submitted a request for minor changes to the Draft Findings of Fact, Conclusions of Law and Order. Ms. Cassetta explained that the wording in the Draft was correct based on the transcript. However, she verified with a Board Medical Consultant that the changes were technically correct.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-05-0781A	AMB	STEVE P. CHOW, M.D.	31428	Accept Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to monitor an anesthetized patient resulting in a respiratory arrest and possible cardiovascular compromise and for failure to maintain adequate records.
9.	MD-05-1119A	M.G.	SUDHIR K. GOEL, M.D.	27103	Issue Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to document the severity of the patient's back pain after several visits and for failure to adequately document subsequent back examinations.
10.	MD-05-0124B	M.M.	ZULFIQAR FAROOQUI, M.D.	24737	Issue Findings of Fact, Conclusions of Law and Order for a Decree of Censure for knowingly making a false statement in connection with the practice of medicine, knowingly making false or fraudulent statement to the Board and for failing to adequately follow up on abnormal lab tests. One year Probation with CME in ethics.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-05-1182A	J.B.	KAREN BARCKLAY-DODSON, M.D.	29446	Accept Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for failure to appropriately evaluate and refer patient with a significant head injury.

Claudia Williams, a friend of the patient was present and spoke during the call to the public. She also filed a complaint against Dr. Barcklay-Dodson, but was not notified of complaint being opened. BB was assaulted in prison, but Dr. Barcklay-Dodson did not refer him to the emergency room and he died as a result of that injury. The medical record indicates BB lost consciousness and Dr. Barcklay-Dodson did not treat him appropriately. Ms. Williams complained that BB's vitals were not taken subsequently because he was released back to his cell when in fact, BB should have been sent for CT scan.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
12.	MD-06-0236A	B.G.	JAMES M. HURLEY, M.D.	3191	Accept Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to evaluate and appropriately diagnose a patient with acute abdominal pain. One year Probation encompassing the differential diagnosis and management of the acute abdomen in both children and adults.
13.	MD-05-0427C	AMB	JOSEPH A. CAPLAN, M.D.	14750	Accept Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to obtain a past medical history and underestimating the severity of a cardiac catheterization complication resulting in the death of a patient.
14.	MD-06-0072A	AMB	STEVEN C. TORRES, M.D.	31282	Accept Findings of Fact, Conclusions of Law and Order for failure to recognize diabetic ketoacidosis in a pregnant patient.
15.	MD-05-0196B	AMB	CHARLES LEW, M.D.	18472	Accept Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to diagnose and treat bowel obstruction in a timely manner in an infant presenting with continued emesis. One year Probation with CME in management of acutely ill pediatric patients.
16.	MD-05-0866A	AMB	TIMOTHY J. GELETY, M.D.	21851	Accept Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for not evaluating a patient who developed post-operative complications and for not being available in a timely fashion to evaluate another post-operative patient.

MOTION: Becky Jordan moved to Accept Findings of Fact, Conclusions of Law and Orders for items 7-16.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
17.	MD-98-0547 MD-99-0407 MD-99-0655 MD-00-0321	E.H. E.B. K.S. R.F.	RICHARD DINSDALE, M.D.	19143	Rescind Referral to Formal Hearing and Dismiss.

Dean Brekke, Assistant Attorney General summarized the case for the Board. The case was referred to the AG's Office in 2003. In two cases there were no deviations from standard of care; however, they were still forwarded to his office. Dr. Dinsdale does not have a prior disciplinary history with the Board. The complaints in this case were numerous, but non legally sustainable. Mr. Brekke recommended that the referral to formal hearing be rescinded and matters be dismissed.

Tim B. Hunter, M.D. stated that it troubled him that these cases appeared on their face to be problematic and that it appears as though the ball was dropped. Mr. Brekke stated that in regard to the allegation of altered medical records there was no evidence on review to show an area on the record where the intraocular pressures could have been recorded, let alone to show it had been changed. The other change to the medical record was legitimate.

MOTION: Tim B. Hunter, M.D. moved to Rescind Referral to Formal Hearing and Dismiss.
SECONDED: Becky Jordan
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
18.	MD-05-0514A	AMB	PAUL SAIZ, M.D.	25767	Deny the motion for Rehearing or Review.

Douglas D. Lee, M.D. recused himself from this case.

Stephen Myers was present and spoke during the call to the public on behalf of Paul Saiz, M.D. Dr. Saiz' decision to not proceed with fusion of L3 vertebra was a conservative treatment. The source of pain was not emanating from L3-4. There is no testimony that L3-4 would have been the source of pain identified through history and physical. There is also no support that he did not perform the surgery planned. Mr. Myers asked that the Board rescind the Draft Findings of Fact, Conclusions of Law and Order and stated that while Dr. Saiz's operative report could have been improved, an Advisory Letter would be more appropriate.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
19.	MD-05-0770A	AMB	RICHARD C. ROTHMAN, M.D.	29754	Grant the Motion for Rehearing or Review and issue an Advisory Letter a minor technical violation in the setting of a laser

Kraig Marton, legal counsel, was present and spoke during the call to the public. The Board's Outside Medical Consultant did not clearly say there was a violation of any standard and two other boards have dismissed their cases against Dr. Rothman. Mr. Marton asked the Board to reconsider because evidence was presented that the standard of care only requires verbal checks, including letters from three well-respected physicians in town who practice the same way. The Board's vote was split at 6-5 and the Board previously issued an advisory letter for a similar case. Dr. Rothman was not disciplined in the state where the event happened or in the state where he is currently practicing.

Tim B. Hunter, M.D. recused himself from this case.

Lorraine Mackstaller, M.D. stated Dr. Rothman is licensed here, but does not practice in this State. She felt the error in this case was made by the technician and the Letter of Reprimand for Dr. Rothman's conduct was excessive. Dr. Mackstaller noted a Board's previous case in which it did not find the physician responsible for the technician's mistake. Two other medical boards did not find Dr. Rothman guilty for his conduct and she did not feel as though Dr. Rothman should be disciplined in a state where he does not work. At most Dr. Mackstaller felt this case should rise to an Advisory Letter.

Christine Cassetta, Board Legal Counsel reminded the Board of their previous discussion regarding wrong site/wrong level surgery and how the Board took this past discussion into consideration when it made its recommendation for a Letter of Reprimand.

Dr. Mackstaller noted the Board previously issued an advisory letter in this case and stated she was concerned about the inconsistency of the Board's decision. Dr. Mackstaller noted the Board acted on a similar case on the same agenda where the physician did not act as thoroughly as the physician did in this case, and yet the complaint was dismissed. Dr. Mackstaller said she did not see the fairness in cases where both physicians trusted their technicians but yet only one case was dismissed. Ram R. Krishna, M.D. said the two cases showed two different scenarios, in that in the case that was dismissed, the physician did not have access to the machine the technician operated. In this case, however, the physician was using the machine, hands-on, although his technician was involved.

Robert P. Goldfarb, M.D. said this case differed from the case that was dismissed as the physician in the other case wrote the correct order and the technician changed the order. Dr. Megdal said, although the Board strives for consistency, sometimes there are facts in cases that warrant departure from the normal policy.

MOTION: Dona Pardo, Ph.D., R.N. moved to deny the Motion for Rehearing or Review.
SECONDED: Ram R. Krishna, M.D.
VOTE: 2-yay, 7-nay, 0-abstain, 1-recuse, 2-absent
MOTION FAILED.

MOTION: Lorraine Mackstaller, M.D. moved to grant the motion for Rehearing or Review.
SECONDED: Ram R. Krishna, M.D.
VOTE: 9-yay, 1-nay, 0-abstain, 1-recuse, 2-absent
MOTION PASSED.

MOTION: Lorraine Mackstaller, M.D. moved to issue an Advisory Letter a minor technical violation in the setting of a laser.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 7-yay, 2-nay, 0-abstain, 1-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
20.	MD-03-0014A	AMB	ZEV FAINSILBER, M.D.	22634	Deny the Motion for Rehearing or Review.

Jay Fradkin, legal counsel for Dr. Fainsilber was present and spoke during the call to the public. Mr. Fradkin said the complainant in this case could not support her allegations with sworn testimony and could not recall the incident. Mr. Fradkin also noted the patient was not the person who filed the complaint in this case. The Board ordered a psychological examination that came back inconclusive. Mr. Fradkin said there is no basis for disciplinary action in his case and such action would force Dr. Fainsilber out of business as having a female healthcare provider with him, as required by the Order, is not economical.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
21.	MD-05-0184A	AMB	RONALD E. SHERER, M.D.	19367	Deny the Motion for Rehearing or Review.
22.	MD-03-0859A	C.B.	JOHN M. RITLAND, M.D.	17268	Deny the Motion for Rehearing or Review.

MOTION: Ram R. Krishna, M.D. moved to deny the motion for rehearing or review for items 18, 20, 21 and 22.
SECONDED: Tim B. Hunter, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
23.	MD-05-0460A	AMB	DANIEL J. MARTINIE, M.D.	29155	Grant Motion for Rehearing or Review for the purposes of correcting the Order language.

Dean Brekke, Assistant Attorney General informed the Board that Dr. Martinie requested a change to the wording of the Letter of Reprimand related to the reference to Article 15. Mr. Brekke submitted a confidential memorandum analyzing the Motion for Rehearing or Review. Mr. Brekke suggested the Board considering re-wording its motion. Sharon B. Megdal, Ph.D. agreed with the language provided by Mr. Brekke as it was more informative than the previous wording.

MOTION: Sharon B. Megdal, M.D. moved to grant the Motion for Rehearing or Review for the purposes of correcting order language.
SECONDED: Douglas D. Lee, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

MOTION: Lorraine Mackstaller, M.D. moved to change the wording in the existing Order to Letter of Reprimand for an action taken by the federal government restricting his practice to male patients only and for engaging in a sexual relationship with a former patient within six months after the last consultation.
SECONDED: Ram R. Krishna, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
24.	MD-04-0097A	AMB	DAVID D. DULANEY, M.D.	7924	Rescind the Referral to Formal Hearing

MOTION: Douglas D. Lee, M.D. moved to rescind the referral to Formal Hearing.
SECONDED: Ram R. Krishna, M.D.
VOTE: 9-yay, 1-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
25.	MD-05-1208A	AMB	MAHENDRA NATH, M.D.	10234	Deny the Appeal of ED Referral to Formal Hearing
26.	MD-05-0086A	AMB	JOHN V. DOMMISSE, M.D.	22164	Deny the Appeal of ED Referral to Formal Hearing

MOTION: Sharon B. Megdal, Ph.D. moved to deny the appeals for items 25 and 26 for ED Referral to Formal Hearing.
SECONDED: Ram R. Krishna, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
27.	MD-05-0164A	J.M.	KENLEY M. REMEN, M.D.	30159	Revocation

Kenley Remen, M.D.'s father was present and spoke during the call to the public. Mr. Remen informed the Board that Dr. Remen was in Israel undergoing treatment and remained ill.

Erica Bouton, Senior Medical Investigator informed the Board that Dr. Remen violated the Board Order by not paying the costs of formal hearing and by not entering treatment as ordered. She recommended the Board lift the stay and revoke Dr. Remen's license.

MOTION: Sharon B. Megdal, Ph.D. moved to Revoke the license.
SECONDED: Tim B. Hunter, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
28.	MD-05-0151A	AMB	JERI B. HASSMAN, M.D.	16132	Grant request for termination of probation.

Jeri Hassman, M.D. was present and spoke during the call to the public. Dr. Hassman said she had taken the Board's criticism to heart and had since studied more about joint injection procedures. Dr. Hassman said she was having difficulty obtaining cooperation to fulfill her Board Order. Dr. Hassman said, however, she has remediated her knowledge of the pharmacology of lidocaine and steroids and can now safely perform joint injections. Dr. Hassman requested the Board to lift the Order of Probation.

Sharon B. Megdal, Ph.D. recused herself from the case.

Sue Dana, Compliance Officer confirmed Dr. Hassman had fufuilled the terms of her Probation Order by obtaining 20 hours Category I CME in pharmacology. Ms. Dana noted, however, the Staff Investigational Review Committee (SIRC) was split on its recommendation and half of the members felt the continuing medical education (CME) Dr. Hassman received was not sufficient to terminate the Board Order. Kelly Sems, M.D., Internal Medical Consultant stated it was her opinion that the injection CME Dr. Hassman had obtained was not sufficient as the CME consisted of a video tape, a syllabus to follow and a post test. Dr. Sems stated the CME obtained by Dr. Hassman met an absolute minimum requirement.

Douglas D. Lee, M.D. noted that on page 70 of the transcript from the meeting where Dr. Hassman's order was issued, the Board discussed that Dr. Hassman should receive mentoring and demonstrate her ability to safely perform procedures. Dr. Lee noted he did not see how Dr. Hassman demonstrated this by watching a video. William R. Martin, III, M.D. recalled that during her formal interview Dr. Hassman could not accurately describe the location of her injections and he had serious concerns with her understanding of anatomy. Tim B. Hunter, M.D. stated the case did not arise out of a patient complaint and he would not have a problem with removing the restriction. Douglas D. Lee, M.D. stated that just because the findings in the case were not as a result of the initial complaint did not mean the Board could not find a deviation from the standard of care.

MOTION: Tim B. Hunter, M.D. moved to grant the request for termination of Probation.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 7-yay, 2-nay, 0-abstain, 1-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
29.	MD-03-0826A MD-05-0154A	AMB	MARTIN L. MEYERS, M.D.	27197	Consent Agreement for Surrender of an active license
30.	MD-06-0903A	AMB	ROBERT J. CLARK, M.D.	8084	Consent Agreement for Surrender of an active license.

Paul M. Petelin, Sr., M.D. recused himself from this case.

MOTION: Ram R. Krishna, M.D. moved to accept the Proposed Consent Agreements for Surrender of an active license for items 29 and 30.
SECONDED: William R. Martin, III, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

Wednesday, December 6, 2006

CALL TO ORDER
The meeting was called to order at 9:30 a.m.

ROLL CALL
The following Board Members were present: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. The following Board Members were not present: Patrick N. Connell, M.D. and Paul M. Petelin, Sr., M.D.

CALL TO PUBLIC
Statements issued during the call to the public appear beneath the case referenced.

Robert Wilder from Life Scape Medical Association spoke during the call to the public on what he considered to be abuse of the physician complaint system. Mr. Wilder said the current process for which to file a complaint against a physician makes it too accessible to anyone who wishes to make a baseless complaint. Mr. Wilder said there is considerable impact on physicians against whom complaints are filed, even if the complaint is meritless. Mr. Wilder stated complaints make an impact on a physician's time, it causes a disruption of their practice and is costs the physician money. Mr. Wilder suggested the Board require the complainant to attest to the facts in their complaint and to require complainants to have their signature signed by a notary public so the Board can prove who they are. Mr. Wilder also suggested requiring a nominal filing fee and eliminating on-line filing in order to reduce spontaneous filing of complaints. Mr. Wilder further asked that the Board publish a statement that, when a complaint has been filed, the complaint is only an allegation and has not been sustained while in the investigation process.

On Thursday, December 7, 2006 the Board discussed Mr. Wilder's concerns. Robert P. Goldfarb, M.D. explained Mr. Wilder's concerns to the Board member who had not heard Mr. Wilder's testimony the previous day. William R. Martin, III, M.D. commented that he appreciated MR. Wilder's comments and thought Mr. Wilder's had good suggestions for the complaint process. Ram R. Krishna, M.D. noted some of the suggestions would require statutory changes if implemented and he suggested the Board agendize discussion of the complaint process for the Board's yearly Off-Site Meeting in the Fall of 2008 when the Board designates time to address such topics.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-05-0963A	M.W.	JOSEPH C. LINDSTROM, M.D.	17253	Issue an Advisory Letter for inadequate medical records.

Joseph Lindstrom, M.D. was present without counsel.

MW was present and spoke during the call to the public. MW presented to Dr. Lindstrom with right-sided abdominal pain and he documented such. MW was concerned there may be some type of malignancy and underwent diagnostic surgery. MW experienced extreme pain upon awakening from the surgery and had a long post-operative recovery. She continued to complain of pain on her right side following surgery and experienced a lump on her right side as well. MW said Dr. Lindstrom removed her left ovary as opposed to her right ovary and without her consent to do so. MW said Dr. Lindstrom's office made harassing phone calls to her for months following her surgery stating she must complete an informed consent for the surgery Dr. Lindstrom had performed. MW said, since the procedure performed by Dr. Lindstrom, she now has to work a sit-down job and cannot work the schedule she previously did.

Ingrid Haas, M.D., Medical Consultant summarized the case for the Board. MW's ultrasound showed a probable right ovarian cyst that had enlarged from a previous evaluation and also showed fluid around the left ovary. Dr. Haas said Dr. Lindstrom did not MW's surgical options until two days after the procedure was carried out. Dr. Lindstrom removed MW's left ovary and did not dictate a note at the time regarding why the left ovary was removed.

Dr. Lindstrom said MW had two prior ultrasounds before seeing him that both showed cysts on both ovaries. Dr. Lindstrom said that, after exploring the area, only the left ovary looked abnormal. Dr. Lindstrom said he expected MW to have pain following the surgery, and saw her only once, two weeks following the procedure and MW then changed practitioners and he could not follow up with her.

Ram R. Krishna, M.D. led the questioning. Dr. Krishna noted Dr. Lindstrom's handwritten history and physical on MW prior to the procedure documented "pelvic bleeding". Dr. Lindstrom said that was an error in his dictation and, actually, when he went into the operating room for MW, his thought was pelvic pain not pelvic bleeding.

Dr. Lindstrom said he removed MW's left ovary because there were adhesions surrounding it. Dr. Lindstrom agrees patients typically have pain on side of the cyst is located; however, Dr. Lindstrom said the pain can sometimes be on the opposite side of the cyst. Dr. Krishna noted Dr. Lindstrom performed surgery on MW on October 14, 2003, but did not dictate the operative note until one month and three days after the operation on November 17, 2003. Dr. Krishna noted Dr. Lindstrom's operative note did not comment on the pathology of MW's right ovary, indicating Dr. Lindstrom was straining to dictate the note from memory long after the procedure. Dr. Lindstrom conceded his time frame for dictating should have been sooner in this case and that this was not his normal procedure.

Robert P. Goldfarb, M.D. noted Dr. Lindstrom's notes first said he was going to free up adhesions around the left ovary, when in fact he removed the left ovary and did not describe why it was removed.

Sharon B. Megdal, Ph.D. noted the Staff Investigational Review Committee (SIRC) did not find actual harm in this case. Dr. Haas explained that finding was made based on her evaluation of the case and finding there is no actual harm in removing one ovary when the other ovary remains and is functional.

Dr. Krishna said he found because of the way the left ovary was incased in the adhesions, as described by Dr. Lindstrom, MW's pain may have come from the left ovary. Dr. Krishna found Dr. Lindstrom's reason for removing the left ovary to be acceptable and noted MW's ultrasound did show a finding on MW's left side. Dr. Krishna said he did find Dr. Lindstrom's documentation to be lacking as his operative note was scanty and was dictated late.

Dona Pardo, Ph.D., R.N. asked Dr. Krishna if he considered requiring Dr. Lindstrom to obtain CME in medical record keeping. Dr. Krishna said he found Dr. Lindstrom's record keeping in this case did not demonstrate a deficiency in his knowledge base, but just rather that he did not document correctly in this case. Dr. Goldfarb noted Dr. Lindstrom's history and physical of MW was dictated and transcribed in a timely manner and noted Dr. Lindstrom had no prior Board history.

MOTION: Ram R. Krishna, M.D. moved to issue an Advisory Letter for inadequate medical records.
SECONDED: Tim B. Hunter, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D, R.N. The following Board Member abstained: Sharon B. Megdal, Ph.D. The following Board Members were absent: Patrick N. Connell, M.D. and Paul M. Petelin, Sr., M.D.
VOTE: 9-yay, 0-nay, 1-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-05-0603B	AMB	KURT F. DICKSON, M.D.	25409	Issue an Advisory Letter for failing to obtain a differential diagnosis of a diabetic patient with hematuria resulting in delayed diagnosis. The actions do not rise to the level of discipline.

Kurt Dickson, M.D. was present with counsel Mr. Sigurds M. Krolls.

Kelly Sems, M.D., Internal Medical Consultant summarized the case for the Board. The Outside Medical Consultant found Dr. Dickson deviated from the standard of care by discharging a patient with joint pain and hematuria without investigating his renal status. Actual harm was found in that Dr. Dickson's delay in the management and treatment of the patient's rapidly deteriorating clinical status led to the patient's death.

Dr. Dickson said, although he feels sorry regarding the outcome of this case, but he provided appropriate care to the patient. Dr. Dickson said diagnosing microscopic hematuria is not necessarily mandated in the emergency department. Dr. Dickson explained that did supervise the physician assistant (PA) involved in this case and he also examined the patient himself and discussed the case with the PA. Dr. Dickson said his examination revealed the patient had no signs or symptoms of pneumonia and the patient's x-ray did not show pneumonia. He has learned from this case to have a higher index of suspicion and perform more testing for diabetic patients.

Lorraine Mackstaller, M.D. led the questioning and noted the patient's joint pain was so severe he presented to the emergency room due to the pain. Dr. Mackstaller noted the dipstick showed the patient was a diabetic who had ketones and hematuria and Dr. Dickson should have checked the patient's blood sugar to know if he had Diabetic Ketoacidosis (DKA). Dr. Mackstaller also noted pneumonias do not always present with respiratory symptoms and Dr. Dickson should have ordered a basic lab for the patient. Dr. Mackstaller noted that the patient still may have died, in spite of a more extensive workup, but Dr. Dickson owed the patient the higher chance of survival and ordering additional lab work would have created a 48-hour head-start in potentially saving the patient's life. Dr. Mackstaller also noted the patient had a very low blood pressure, especially in light of his severe joint pain and this could have indicated possible sepsis. Dr. Mackstaller said there were multiple red flags in this case that Dr. Dickson overlooked.

Tim B. Hunter, M.D. noted Dr. Dickson diagnosed the patient as being dehydrated, but did not get the patient's electrolyte status before administering further fluids.

Mr. Krolls said the diagnosis of this patient was difficult and Dr. Dickson based his diagnosis on his personal observations of the patient. Mr. Krolls said Dr. Dickson properly instructed the patient to follow up with his primary care physician the following morning. Subsequently, Dr. Dickson has learned from this experience and has further improved his practice.

Dr. Mackstaller said she did not find issues with Dr. Dickson's supervision of the PA because Dr. Dickson physically examined the patient and was aware of the patient's urinalysis results. Dr. Mackstaller noted, although the patient had an abnormal urinalysis, Dr. Dickson did not perform additional workup. Dr. Mackstaller said further work up was warranted, especially in light of the patient's symptoms (such as the low blood pressure) of a more ominous problem. Dr. Mackstaller stated the standard of care when a patient is seen in the emergency room with co-morbid issues and an abnormal urinalysis to perform additional work up prior to discharge. Dr. Mackstaller found Dr. Dickson deviated from the standard of care by failing to recognize the seriousness of patient's presentation and for failing to obtain the necessary screening lab work.

MOTION: Lorraine Mackstaller, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Ram R. Krishna, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

William R. Martin, III, M.D. spoke in favor of the motion. Dr. Martin noted, although the patient did not have the traditional signs of pneumonia and other physicians also missed the patient's diagnosis, it still did not excuse Dr. Dickson from making the correct diagnosis. Dr. Martin noted there was no reason why Dr. Dickson did not order additional lab work for the patient. Dr. Mackstaller noted diabetic patients are at higher risk for strange presentations of infectious processes.

MOTION: Lorraine Mackstaller, M.D. moved to Draft Finding of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing to obtain a differential diagnosis of a diabetic patient with hematuria resulting in a delayed diagnosis.
SECONDED: Ram R. Krishna, M.D.

Tim B. Hunter, M.D. spoke against the motion stating Dr. Dickson has since modified his behavior and the Board should not look at the case retrospectively by allowing the outcome of the case influence the facts at the time Dr. Dickson saw the patient. Douglas D. Lee, M.D. and Robert P. Goldfarb, M.D. agreed with Dr. Hunter stating the case did not rise to the level of disciplinary action. Dr. Goldfarb found it mitigating that Dr. Dickson had no prior Board actions. Dr. Goldfarb also found it mitigating that the patient's primary care physician saw the patient the day after Dr. Dickson discharged him, and also could not determine the correct diagnosis.

Ram R. Krishna, M.D. spoke in support of the motion, stating the signs showed possible sepsis and further workup was necessary. Dr. Martin also spoke in favor of the motion stating there were many red flags in the patient's presentation and Dr. Dickson missed the opportunity for the patient to have a better outcome.

Dr. Goldfarb also found it mitigating that Dr. Dickson personally performed a hands-on examination of the patient and did not delegate the examination to the PA. Dr. Mackstaller said the fact Dr. Dickson did perform a hands-on examination, personally saw the patient's lab work and still missed the diagnosis was not mitigating, but made the deviation more egregious.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patricia R.J. Griffen , Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D. and Sharon B. Megdal, Ph.D. The following Board Members voted against the motion: Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Douglas D. Lee, M.D. and Dona Pardo, Ph.D., R.N. The following Board Members were absent: Patrick N. Connell, M.D. and Paul M. Petelin, Sr., M.D.
VOTE: 5-yay, 5-nay, 0-abstain, 0-recuse, 2-absent
MOTION FAILED.

MOTION: Tim B. Hunter, M.D. moved to issue an Advisory Letter for failing to obtain a differential diagnosis of a diabetic patient with hematuria resulting in delayed diagnosis. The actions do not rise to the level of discipline.
SECONDED: Becky Jordan
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Douglas D. Lee, M.D., William R. Martin, III, M.D. and Dona Pardo, Ph.D., R.N. The following Board Members voted against the motion: Patricia R.J. Griffen, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D. and Sharon B. Megdal, Ph.D. The following Board Members were absent: Patrick N. Connell, M.D. and Paul M. Petelin, Sr., M.D.
VOTE: 6-yay, 4-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-04-0282A	AMB	ZULFIQAR AHMAD, M.D.	28404	Dismiss.

Zulfiqar Ahmad, M.D. was present with counsel Mr. Stephen Myers.

William Wolf, M.D., Medical Consultant summarized the case for the Board. Dr. Wolf said the Arizona Medical Board (Board) received notification that Phoenix Baptist Hospital had suspended Dr. Ahmad's cardiac invasive procedure privileges due to quality of care concerns. The Board reviewed nine of Dr. Ahmad's cases and found deviations in three of the cases. Dr. Wolf said the deviation in the first case (patient DJW, a 61 year-old female) was that Dr. Ahmad performed a cardiac catheterization and angioplasty for DJW when she was not a surgical candidate and in her condition and for whom the procedure was not indicated. For the second patient (ND, a 49-year-old female) Dr. Ahmad deviated from the standard of care in his incorrect interpretation of several images and in over-reading the evidence of ND's disease. Dr. Ahmad performed surgery for ND without adequate indication. In the case of the third patient (VB, a 78-year-old female) Dr. Ahmad deviated from the standard of care by failing to document pre-procedure distal pulses and failing to document indication for the procedures. Dr. Wolf also noted Dr. Ahmad's prior Board history to be an aggravating factor.

Lorraine Mackstaller, M.D. led the questioning. Dr. Mackstaller noted that in the case of DJW, she was on steroids which could have been the cause of her atrial fibrillation. Dr. Mackstaller questioned Dr. Ahmad why, toward the end of DJW's hospitalization, despite progress notes stating the patient felt well, wanted to go home and there was no documentation of any chest pain or shortness of breath, yet Dr. Ahmad proceeded with a cardiac catheterization. Dr. Mackstaller noted DJW had been treated for Methicillin-Resistant Staphylococcus Aureus (MRSA) pneumonia while in the hospital and Dr. Ahmad should have waited for DJW to be further out from infection before performing a heart catheterization. Dr. Ahmad stated DJW was anxious to return to her home in California and follow up with a physician there. However, Dr. Ahmad said he was concerned DJW may not follow up in a timely fashion and a delay of cardiac catheterization may result in her sudden death.

Dr. Mackstaller noted DJW subsequently had a recognizable complication of the procedure and the complication was not considered below the standard of care.

Dr. Mackstaller noted that in the case of ND, she was initially concerned that Dr. Ahmad performed three cardiac catheterizations for the patient within three months and the patient continued to be symptomatic. However, Dr. Mackstaller said the anatomy of a woman's coronary system is that they lay down cholesterol differently than men and the patient's Intravascular Ultrasound (IVUS) showed the patient had a strange presentation of cardiovascular disease. Dr. Mackstaller said she found Dr. Ahmad did not deviate from the standard of care in this case.

In the case of patient VB, Dr. Mackstaller noted Dr. Ahmad documented the patient's peripheral pulses only once in the chart. Dr. Mackstaller also noted Dr. Ahmad did not find the patient had claudication issues until the patient was on the operating table and Dr. Ahmad also did not document the symptoms of the patient's claudication. Robert P. Goldfarb, M.D. said he did not find Dr. Ahmad deviated from the standard of care. Dr. Goldfarb noted Dr. Ahmad does now document peripheral pulses pre-operatively. Tim B. Hunter, M.D. noted Dr. Ahmad now also documents his rationale for taking a patient to surgery more efficiently than in the past.

Dr. Mackstaller said she found the suspension of Dr. Ahmad's privileges to be a turf battle as the Hospital did not find harm in Dr. Ahmad's medical therapy for patient DJW. Dr. Mackstaller stated, for patient ND, the IVUS showed Dr. Ahmad made the correct decisions in the patient's care. Dr. Mackstaller said in the case of patient VB, Dr. Ahmad showed good clinical judgment as proved by the later results of the aortogram. Dr. Mackstaller noted Dr. Ahmad was triple board certified and had no medical malpractice actions or Board actions. Dr. Mackstaller said she found, after listening to Dr. Ahmad's rationale in the three cases, she found he did not deviate from the standard of care.
MOTION: Lorraine Mackstaller, M.D. moved to Dismiss the case.
SECONDED: William R. Martin, III, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. The following Board Members were absent: Patrick N. Connell, M.D. and Paul M. Petelin, Sr., M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-05-0695B	M.T.	WILLIAM H. CASTRO, M.D.	18402	Issue an Advisory Letter for failure to take further steps to timely evaluate a patient for possible ectopic pregnancy resulting in a ruptured fallopian tube. This matter does not rise to the level of discipline.

William Castro, M.D. was present with counsel Mr. Stephen Myers.

Ingrid Haas, M.D., Medical Consultant summarized the case for the Board. Dr. Haas said Dr. Castro deviated from the standard of care by failing to timely diagnose and treat an ectopic pregnancy. Actual harm was found in that, due to the delay in Dr. Castro's diagnosis, the patient sustained a ruptured ectopic pregnancy, laparotomy and loss of her fallopian tube.

Dr. Castro said the patient was basically free of symptoms at the time he saw her. Dr. Castro said he discussed the options with the patient and proceeded to perform a Dilation and Curettage (DNC) without complications. Dr. Castro said the patient did not have any villi following the surgery and he counseled the patient regarding the symptoms of ectopic pregnancy to present to the emergency room if such complications occurred. Dr. Castro said he was about to further explore ectopic pregnancy for the patient when he was informed she had presented to the emergency room for an ectopic pregnancy.

Robert P. Goldfarb, M.D. led the questioning. Dr. Goldfarb noted Dr. Castro noted the patient had bloody vaginal secretion yet he did not act in an emergent manner. Dr. Goldfarb stated Dr. Castro could have ordered a non-invasive transvaginal ultrasound in order to quickly determine whether the patient had an ectopic pregnancy rather than performing a DNC. Dr. Goldfarb noted the patient was in the emergency room on June 21, 2005 and on June 24, 2005 and yet Dr. Castro was not concerned enough to order a transvaginal ultrasound. Dr. Goldfarb further noted on July 17, 2005 Dr. Castro had a pathology report the patient had no villi and at that point she still had the potential for an ectopic pregnancy, yet Dr. Castro still did not order a transvaginal ultrasound. Dr. Goldfarb noted Dr. Castro said there was no value in doing a transvaginal ultrasound on July 17, 2005 because one had been done on June 12, 2005 and the patient's clinical findings did not necessitate another ultrasound at that time. Dr. Goldfarb noted Dr. Castro should have been trying to determine the patient's diagnosis within the shortest period of time especially with the potential for ectopic that could rupture at anytime and could result in death.

Tim B. Hunter, M.D. noted Dr. Castro has now changed his practice to apply a more liberal use of radiologic techniques such as the transvaginal ultrasound.

Mr. Myers said Dr. Castro had an almost completely unblemished record. Dr. Castro also said several experts gave their opinion that Dr. Castro did not fall below the standard of care. Mr. Myer said the use of a transvaginal ultrasound is not the standard of care.

Dr. Goldfarb said the issues he found in this case was that, whether or not the standard of care was to use a transvaginal ultrasound or another radiologic technique, it was standard of care for Dr. Castro to make a diagnosis for the patient in a timely fashion. Dr. Goldfarb noted several weeks had past since the patient had first presented in the emergency room. Dr. Goldfarb found Dr. Castro deviated from the standard of care by failing to timely diagnose ectopic pregnancy. The actual harm in this case was a ruptured ectopic tube and the potential harm was hemorrhagic shock and death.

MOTION: Robert P. Goldfarb, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Tim B. Hunter, M.D.
VOTE: 8-yay, 0-nay, 2-abstain, 0-recuse, 2-absent
MOTION PASSED.

Dr. Goldfarb said Dr. Castro should have proceeded to treat the patient with haste in a situation that may be devastating. Dr. Goldfarb noted it was mitigating that Dr. Castro had no prior board history.

MOTION: Robert P. Goldfarb, M.D. moved to issue an Advisory Letter for failure to take further steps to timely evaluate a patient for possible ectopic pregnancy resulting in a ruptured fallopian tube. This matter does not rise to the level of discipline.
SECONDED: Tim B. Hunter, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D. and Dona Pardo, Ph.D, R.N. The following Board Member abstained: Sharon B. Megdal, Ph.D. The following Board Members were absent: Patrick N. Connell, M.D. and Paul M. Petelin, Sr., M.D.
VOTE: 9-yay, 0-nay, 1-abstain, 0-recuse, 2-absent
MOTION PASSED.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-06-0489A	AMB	MARJORIE ALEXANDER, M.D.	N/A	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for habitual intemperance.

Marjorie Alexander, M.D. was present without counsel.

Lorraine Mackstaller, MD said she is on the staff of the residency program where Dr. Alexander trained. Both Dr. Mackstaller and Dr. Alexander agreed they had not met. Therefore, Dr. Mackstaller did not recuse herself from the case.

Chris Banys summarized the case for the Board. Dr. Alexander applied for an Arizona Medical Board post-graduate training permit and disclosed her prior substance abuse and psychiatric history. Dr. Alexander entered into a Stipulated Health Agreement for Drug and/or Alcohol Monitoring on June 21, 2006 and was issued a Residency Permit. On June 26, 2006 the Board received an anonymous call alleging Dr. Alexander had relapsed. Dr. Alexander admitted she had relapsed on May 26, 2006. Board staff advised Dr. Alexander that, due to her admitted relapse, in accordance with the terms of the Agreement dated June 21, 2006, the Agreement was null and void. Dr. Alexander then signed an Interim Consent Agreement for Practice Restriction on June 27, 2006.

Dr. Alexander said she admitted to relapsing and expressed her desire to comply with the Board's direction. Dr. Alexander said she had completed inpatient treatment from July 2006 to August 2006 and had followed up with outpatient therapy. Dr. Alexander said she actively attends bi-weekly counseling, AA meetings and is enrolled in random drug testing. Dr. Alexander said she would agree to sign the Consent Agreement the Board offered to her prior to the meeting.

MOTION: Ram R. Krishna, M.D. moved to go into Executive Session for legal advice.
SECONDED: Tim B. Hunter, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

The Board went into Executive Session for legal advice at 3:33 p.m.
The Board returned to Open Session at 3:40 p.m.
No deliberations or decisions were made during Executive Session.

Ram R. Krishna, M.D. said that since Dr. Alexander had admitted to the allegations, the Board was bound by statute to take disciplinary action. Dr. Krishna noted Dr. Alexander had agreed, under oath, to sign the Consent Agreement.

MOTION: Ram R. Krishna, M.D. moved to offer a Consent Agreement for Practice Restriction due to habitual intemperance
SECONDED: William R. Martin, III, M.D.

Sharon B. Megdal, Ph.D. spoke against the motion stating Dr. Alexander had a chance to sign the Consent Agreement prior to accepting an invitation to come to the Formal Interview. Tim B. Hunter, M.D. spoke against the motion stating he was not convinced she understood the weight of the Letter of Reprimand she would consent to.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., and William R. Martin, III, M.D. The following Board members voted against the motion: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Members were absent: Patrick N. Connell, M.D. and Paul M. Petelin, Sr., M.D.
VOTE: 5-yay, 5-nay, 0-abstain, 0-recuse, 2-absent
MOTION FAILED.

Dr. Krishna noted Dr. Alexander was not currently seeing a psychiatrist and was not currently in group therapy. Dr. Krishna noted Dr. Alexander's future plans were to return to a residency program. Ms. Banys said that if Dr. Alexander were to reapply for new residency permit, Staff would recommend long-term residential treatment as for any physician who has relapsed. Ms. Banys noted Dr. Alexander had currently completed only 30 days of treatment at the Betty Ford Center.

Dr. Krishna made a finding of habitual intemperance A.R.S. §32-1401 (27)(f).

MOTION: Ram R. Krishna, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(f) - Habitual intemperance in the use of alcohol or habitual substance abuse.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

William R. Martin, III, M.D. said he was impressed by Dr. Alexander's candor; nevertheless, the Board did not have a choice other than to find unprofessional conduct.

MOTION: Ram R. Krishna, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for habitual intemperance.
SECONDED: Patricia R.J. Griffen
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D, R.N. The following Board Members were absent: Patrick N. Connell, M.D. and Paul M. Petelin, Sr., M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-05-1183A	AMB	MALCOLM I. BULL, M.D.	31145	Dismiss.

Malcolm Bull, M.D. was present without counsel.

Gerald Moczynski, M.D., Medical Consultant summarized the case for the Board. Dr. Bull deviated from the standard of care by failing to notice the errors made by both the physicist and the radiation technologist until after damage was done to the patient. There was actual harm in this case in that the patient received a larger than appropriate radiation dose that resulted in injury to her breast.

Dr. Bull said he did not recognize during the course of radiation therapy that an excess does of radiation had been given to the patient. Dr. Bull said the excess dose was not recognizable until six months after the administration.

Tim B. Hunter, M.D. led the questioning and asked Dr. Bull why he was unable to recognize that the patient was not given the correct dose. Dr. Bull explained the process and stated the basic calculations are done by the computer after he determines what type of treatment seems the most appropriate. Dr. Bull said he chooses the treatment plan off of a computer screen. The treatment computer is different than treatment planning computer where the information is transferred to. Dr. Bull explained, when the technician transferred the information to the planning computer, it second computer would not accept the formula for the order Dr. Bull had signed and the technician changed the fields without telling the physicist or Dr. Bull. Dr. Bull explained their checks and balances system was to review the films prior to the procedure but the films were checked against the second computer and looked correct. Dr. Bull said he had a meeting with the CEO of the company who wrote the software program and the program has better checks in place and no longer makes the error of not accepting the formula. He has also eliminated the step of the technician transferring the data to the second computer, as the information is automatically transferred now. Dr. Bull said he also does his own chart calculations now.

Robert P. Goldfarb, M.D. noted Dr. Bull saw the patient for each visit and should have noticed there was a high number of monitor units delivered with each treatment. Dr. Bull said he was concerned initially but when he asked a superior about the dosage, he was told it was not a high dose.

William R. Martin, III, M.D. found that Dr. Bull could not have supervised the numbers the technician input into the planning computer. Dr. Bull said the radiation therapy chief technician supervises the other technicians.

Dr. Hunter found the Outside Medical Consultant's Report to be in support of Dr. Bull. Dr. Hunter said this case follows the example of, when a physician writes a prescription, the physician is not responsible to follow the nurse and ensure the prescription is given correctly.

MOTION: Tim B. Hunter, M.D. moved to Dismiss the case.
SECONDED: Becky Jordan

Dr. Martin spoke in support of the motion but said he was concerned had issued discipline on previous cases where a technician has made an error and yet the Board has held the physician responsible. Dr. Hunter said it is the details from case to case that make all the difference on whether or not discipline is given. Dona Pardo, Ph.D., R.N. agreed with Dr. Hunter's example and found that when put in that light, the physician is not responsible for carrying out the order he has signed.

Christine Cassetta, Board Legal Counsel said she understood the Board to be making a factual distinction between two different types of cases where the technician is involved in an error. Ms. Cassetta said the previous case where discipline was issued was different because the technician handed the incorrect order back to the physician before the physician proceeded, leaving the physician with the chance to check the accuracy of the Order one final time.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D, R.N. The following Board Members were absent: Patrick N. Connell, M.D. and Paul M. Petelin, Sr., M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-05-0861A	AMB	MITCHELL R. HALTER, M.D.	29626	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for inadequate management of eight patients. 2 year Probation restricting him from implanting pain management related devices until the doctor has obtained further training in the techniques of implantation and the treatment of complications of the implanted devices acceptable to the Board, specifically, 20 hours CME in implantation of pain management devices and management of complications. He may not apply for modification of the restriction for at least six months.

Becky Young was present and spoke on behalf of Dr. Halter during the call to the public. Ms. Young stated she was a nurse and neither she nor other nurses can imagine an allegation against Dr. Halter claiming he would conduct improper sterile technique or practice in a way that was unprofessional. Ms. Young said she had first hand knowledge of Dr. Halter's skill and has allowed him to perform procedures on her as well.

WG, a patient of Dr. Halter's, was present and spoke during the call to the public. WG spoke in support of Dr. Halter stating Dr. Halter was the first physician in 18 years who was able to give him relief for his extensive neck injuries. WG explained he had been on narcotics for 18 years while trying to cope with his pain, but due to Dr. Halter's care he was able to discontinue his narcotics.

Bennet Davis, M.D. was present and spoke during the call to the public. Mr. Davis said he was the Pain Fellowship director for Dr. Halter and has since been practicing with Dr. Halter in private practice. Mr. Davis summarized Dr. Halter's background and testified to the adequacy of Dr. Halter's training.

Mitchell Halter, M.D. was present with counsel Mr. Daniel Jantsch.

Lorraine Mackstaller, M.D. recused herself from the case. Robert P. Goldfarb, M.D. said he had heard of Dr. Halter and Dr. Bennet, but he did not know them and it would not effect his ability to adjudicate the case Tim B. Hunter, M.D. said he had been treated by Dr. Halter, but it would not affect his ability to adjudicate the case.

Carol Peairs, M.D., Medical Consultant summarized the case for the Board. Dr. Peairs said she reviewed the medical records of eight patients and the following allegations were made in Dr. Halter's care of each patient:

- Patient EL suffered a cardiac arrest following Dr. Halter's performance of a thoracic epidural sensory blockade in an unmonitored setting.
- Patient SM had two episodes of respiratory failure following Dr. Halter's implantation of an intrathecal infusion pump.
- Patients SF, LF, JB, WS and LS developed infections related to implanted devices and subsequent management of the infections. In each of these cases Dr. Halter failed to remove some or the entire implanted device requiring subsequent surgery for persistent/recurrent infections and/or removal of foreign material.
- Patients JZ and WS had placement of a peripheral nerve stimulator in an unconventional location.

Douglas D. Lee, M.D. led the questioning and began with questions regarding patient EL. Dr. Halter agreed it was the standard of care to do all procedures in a monitored setting. Dr. Lee noted the chart did not show there was monitoring in place for EL. Dr. Lee noted the nurses did not record EL's blood pressure during the procedures in this case. Dr. Halter said the monitors were place although it was not recorded in the medical record.

Dr. Lee noted, for patient SM, who had a movement disorder, it was Dr. Halter's testimony that oral Baclofen was not effective for this patient because SM did not have a spasticity disorder. Dr. Lee noted Dr. Halter administered Morphine to the patient and that could have been contributory to her condition. Dr. Lee noted Dr. Halter did not document the Baclofen was not effective and had caused the patient problems. Subsequently, the hospitalist doubled the patient's Baclofen dose and discharged her. SM returned to the hospital with respiratory failure.

Dr. Lee noted in the case of patient SF, Dr. Halter left an implanted device in after she came back to have her sutures removed. Dr. Lee noted it was the standard of care to remove all implanted material in the face of the infection. Dr. Halter said SF's diabetes was difficult to control and therefore, it took a longer time for her wounds to heal. Dr. Halter said he left the implanted device in because he knew he would need it for another procedure and wanted to perform as few procedures as possible due to her prolonged recovery time.

Tim B. Hunter, M.D. noted Dr. Halter is no longer implanting devices such as in this case and now, is documenting better when there is a major change in a patient's medication. Dr. Krishna noted Dr. Halter is no longer performing peripheral nerve stimulators.

Dr. Halter said he takes pride in the fact that other experts send their patients to him. Dr. Halter said that in his care of high-risk patients, he has had the patient's best interest in mind for providing the most cutting-edge effective treatment for people who often have no hope. Dr. Halter admitted that each case showed some judgment errors but they were not the type of errors that were beyond what all physicians make at some time.

Mr. Jantsch said Dr. Halter is an asset to society as witnessed by the patient's testimony during the call to the public.

Dr. Peairs noted some deviations in the case stating for SM, in order to treat the stump twitching, it would be logical to start with a low dose of medication and slowly titrate upward to prevent spasticity. In the case of SF, Dr. Halter did not perform a routine suture removal.

Douglas D. Lee, M.D. found Dr. Halter fell below the standard of care in treatment of all of the patients in this case.

MOTION: Douglas D. Lee, M.D. moved to find moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(e)- Failing or refusing to maintain adequate records on a patient, A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public and A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Tim B. Hunter, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 1-recuse, 2-absent
MOTION PASSED.

Dr. Hunter said Dr. Halter's documentation was inadequate as others may not be able to assume care from his medical records. Dr. Lee said he had a problem with each of the cases regarding Dr. Halter's recognition and management of each of the complications. Dr. Lee said he also found it below the standard of care that Dr. Halter did not remove the infected device in SF and clean it before leaving it in SF.

The Board went into Executive Session for legal advice at 5:50 p.m.
The Board returned to Open Session at 5:58 p.m.
No deliberations or decisions were made during Executive Session.

Dr. Lee clarified the motion for unprofessional conduct stating Dr. Halter deviated from the standard of care for patient EL by performing a thoracic epidural regional anesthetic in a hospital room without monitoring, by failing to monitor post-procedure vital signs, without immediate access to resuscitative medications and equipment and by leaving EL unattended and unmonitored minutes after onset of sensory blockade. Dr. Lee found the administration of Oral Baclofen for patient SM did not fall below the standard of care. However, Dr. Lee found Dr. Halter deviated by implanting a permanent intrathecal infusion pump instead of conservatively treating SM with the oral Baclofen. Dr. Lee also found Dr. Halter deviated from the standard of care by treating SM with Morphine after Baclofen had already been proven to resolve SM's problems. Dr. Halter also deviated from the standard of care in SM in that he did not recognize intrathecal Baclofen overdosage presents a somnolence and respiratory depression and can be potentiated by intrathecal Morphine. Finally in the case of SM, Dr. Halter deviated by failing to titrate Baclofen upward rather than starting at a high dose. Dr. Lee concurred with the Staff Interim Review Committee's (SIRC's) standard, deviation, and actual and potential harm for the following patients; SF, LF, JB, WS , LS and JZ. Dr. Lee said he did not have issues of experimentation in these cases but rather with Dr. Halter's inadequate documentation.

MOTION: Douglas D. Lee, M.D. moved to Draft Finding of Fact, Conclusions of Law and Order for a Decree of Censure for mismanagement of eight patients and Five year Probation restricting him from performing or implanting devices until doctor has obtained further training in the techniques of implantation and the complications of treatment of the implanted device. He may not apply for modification for at least one year.

This motion was not seconded and therefore failed.

Dona Pardo, Ph.D., R.N. suggested ordering Continuing Medical Education (CME) as the Board had found a medical records violation. Sharon B. Megdal, Ph.D. found it mitigating that the complaints in this case did not come from the patients in this case.

MOTION: Sharon B. Megdal, Ph.D. moved to draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for inadequate management of eight patients. 2 year Probation restricting him from implanting pain management related devices until the doctor has obtained further training in the techniques of implantation and the treatment of complications of the implanted devices acceptable to the Board, specifically, 20 hours CME in implantation of pain management devices and management of complications. He may not apply for modification of the restriction for at least six months.
SECONDED: William R. Martin, III, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Member voted against the motion: Douglas D. Lee, M.D. The following Board Member abstained: Robert P. Goldfarb, M.D. The following Board Member was recused: Lorraine Mackstaller, M.D. The following Board Members were absent: Patrick N. Connell, M.D. and Paul M. Petelin, Sr., M.D.
VOTE: 7-yay, 1-nay, 1-abstain, 1-recuse, 2-absent
MOTION PASSED.

Dr. Lee spoke against the motion stating a Decree of Censure was warranted considering the serious nature of the case. Dr. Lee said there was a clear pattern of problems in the cases. Dr. Lee also said the phrase "mismanagement of eight patients" was more fitting than "inadequate management".

OTHER BUSINESS

Approval of Evaluation and Treatment of Physicians with Abuse Diagnosis

Current Trends in Abuse Diagnosis

David Greenberg, M.D., Board Addictionologist explained there was a new trend in abuse diagnosis that distinguishes a difference between substance abuse and substance dependence. He said, in the past, treating people with a diagnosis of substance abuse was at times over-treating people who were not substance abuse dependent. Dr. Greenberg explained that individuals who are substance dependent cannot break the cycle and are distinguishable from individuals who are simply substance abusers.

Dr. Greenberg suggested the implementation of Diagnostic Abuse Monitoring to comply with the current diagnostic trend. Dr. Greenberg explained that by monitoring physicians who are diagnosed with substance abuse, those who are truly substance dependent will be known as substance dependent individuals usually cannot go a year or two before they receive a positive drug screen. Dr. Greenberg said this type of monitoring is also effective because it is usually something both physician's and their attorney's will readily agree to initially and if a positive drug screen occurs, an agreement is easily made for the physician to enter treatment.

Tim B. Hunter, M.D. said he was proud of the Board's current monitoring program in place and was concerned that with monitoring certain physicians differently than others, certain physicians currently enrolled in the Board's monitoring program will be taking a step backwards. Dr. Hunter said he felt that the current monitoring program that includes a five year Probation may be more incentive for substance abusers to abstain.

Dr. Greenberg said that, from a legal standpoint, the Board can no longer say to someone who has a substance abuse diagnosis that they have to undergo full chemical dependence treatment. Dr. Greenberg admitted there would be an increased risk for placing physicians back to work after they were found driving under the influence (DUI) or impaired on job. However, Dr. Greenberg said he legally could not find a way out of keeping someone, without a substance dependency diagnosis out of work. Dr. Greenberg said The Betty Ford Center will not recommend treatment for individuals with substance abuse, but will only recommend monitoring, and it would be hard for the Board to supersede that. Christine Cassetta, Board Legal Counsel if only have an abuse diagnosis cannot make a finding of habitual intemperance to get them into the Monitoring Aftercare Program (MAP).

Dr. Hunter said the MAP program has been effective for years and if it came down to a legal argument, the court would side with the Board. Kathleen Muller, Physician Health Program Manager said within the last six months, in-patient treatment centers are now sending back recommendations saying certain individuals do not need treatment, whereas before, in-patient treatment was widely recommended for all. Dr. Greenberg said he believed the recent reason for the change in treatment centers recommendations has been because of successful legal challenges that have put pressure on evaluation centers across the United States to clearly define what stage of the disease a person is in.

Dean Brekke, Assistant Attorney General advised the Board that because of the evolving standard for diagnosing substance abuse verses substance dependence, the Board may begin to see more legal challenges to their approach at monitoring. Mr. Brekke said the monitoring program as suggested by Dr. Greenberg would allow the Board to have control over substance abusers and keep a record in case a second incident of abuse occurred. Ms. Cassetta noted that without the new, proposed Stipulated Rehabilitation Agreement for substance abuse diagnosis, the Board would have no other option than to dismiss cases with substance abuses diagnosis. Dr. Krishna also noted more people may begin to self-reporting for substance abuse since the monitoring would be confidential.

MOTION: Ram R. Krishna, M.D. moved to approve the Stipulated Rehabilitation Agreement for substance abuse diagnosis.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

Dona Pardo, Ph.D., R.N. noted the new Stipulated Rehabilitation Agreement will be similar to the current MAP program as the physician will still undergo random drug screening, yet for a shorter period of time. Sharon B. Megdal, Ph.D. noted, however, with the new Stipulated Rehabilitation Agreement, physicians with the substance abuse diagnosis do not have to complete treatment first before undergoing monitoring.

Dr. Martin suggested the new Stipulated Rehabilitation Agreement include additional drug testing within the first 90 days of the monitoring. Dr. Krishna did not modify the motion to reflect such but said, rather, that the Minutes should reflect that additional testing, as needed, could be performed within the first 90 days of the monitoring period.

Thursday, December 7, 2006

CALL TO ORDER
The meeting was called to order at 8:00 a.m.

ROLL CALL
The following Board Members were present: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Ram R. Krishna, M.D., Douglas D. Lee, M.D., Sharon B. Megdal, Ph.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Member was absent: Patrick N. Connell, M.D. The following Board Member arrived at the meeting at 8:10 a.m.: Becky Jordan

CALL TO THE PUBLIC
Statements issued during the call to the public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0058A	R.L.	JOEL A. FALK, M.D.	27031	Issue an Advisory Letter for a minor technical violation.

Joel Falk, M.D. was present with counsel Mr. Barry McBan.

Robert P. Goldfarb, M.D. said he knew Mr. McBan but it would not affect his ability to adjudicate the case.

Ingrid Haas, M.D., Medical Consultant summarized the case for the Board. She stated Dr. Falk deviated from the standard of care by injuring a patient's aorta, requiring massive amounts of blood products. The injury was caused by the introduction of the laparoscopic instruments. Actual Harm was the laceration of the patient's mesentery aorta necessitating massive transfusions and an extended hospitalization. Potential harm was determined that the laceration of the patient's mesentery and aorta could have resulted in death.

William R. Martin, III, M.D. led the questioning. Dr. Martin noted the patient did not become hypotensive at the beginning of the surgery. Dr. Martin noted in his response to the Board Dr. Falk mentioned the trochar malfunctioned and that helped to cause an injury. Dr. Falk said in last couple years physicians have converted to using trochars that have no sharp point, reducing the chance of injury. RL had previous surgeries and her tissue was probably somewhat weakened. Dr. Martin noted that although Dr. Falk knew of RL's previous surgeries he did not take any extra precautions, although there might have been adhesions. Dr. Martin thought an open procedure may have been a better option.

Dr. Martin noted there was an allegation of improper or lack of a history and physical examination. Dr. Falk agreed it was the standard of care to do a timely history and physical. Dr. Martin noted the medical record showed no examination of the patient's vulva and vaginal cavity for more than a year and a half prior to surgery. Dr. Falk said the condition of her fibroids were seen fairly recently on ultrasound. Dr. Martin noted the patient may have co-existent lesions that would have been revealed on examination.

Dr. Martin asked how Dr. Falk would practice change so this would not occur again. Dr. Falk stated when it comes to patients with and without prior surgery the medical literature shows no difference in patient outcomes. However, this was an unusual case that had an unfortunate outcome. If he had to do again he would not go in above the belly button because of angle of decent. In this case the patient asked him to make the incision above the belly button because of previous surgeries. Dr. Falk did not see how he could have done anything differently regarding her tissue considering her past surgery.

Ram R. Krishna, M.D. noted there were also lateral wall and posterior wall lacerations in addition to the aortic laceration. Dr. Haas said the lateral and posterior wall lacerations are know complications, and with the location of the incision as Dr. Falk explained, the trochar can go high enough to hit the aorta.

Paul M. Petelin, Sr., M.D. asked questions about the prior procedures patients had in that area. Dr. Falk stated the patient had an appendectomy and that colectomy were done laparoscopically. Both procedures were done with supraumbilical incisions and he used the same incision site for good cosmetic results. He admitted an open laparoscopy would have been safer especially in the face of prior abdominal procedures and prior scar tissue. Dr. Petelin noted in patients with previous incisions the skin at the incision site is thicker and denser from scar tissue and actually harder to penetrate. The patient was fairly thin and the incident of major vascular injuries is greater in thinner people. Dr. Petelin asked what Dr. Falk has done to improve his technique. Dr. Falk said that when available he uses a bladeless trocar and in the future he would not incise above the umbilicus. Dr. Petelin noted there was a year between the events and this case and the adaptation of the bladeless trocar. Dr. Falk continued to practice laparoscopic procedures in the same way up to a year later. The mortality is high from a 10 or 12 millimeter trochar.

Mr. McBan said they submitted medical literature published by the physician who trained Dr. Falk that deals with issues of open verses a laparoscopic technique and there are no benefits from the gynecologic perspective statistically in the terms of the approach.

Dr. Martin said the tissue would be thicker with someone who had prior surgeries even though Dr. Falk stated additional precautions do not need to be taken for patients who have had prior surgery. Dr. Martin found Dr. Falk did not perform a proper history and physical examination. However, the patient's injury was a known complication.

MOTION: William R. Martin, III, M.D. moved to Dismiss the case.
SECONDED: Lorraine Mackstaller, M.D.

Dr. Petelin spoke against the motion and stated that while the case does not rise to the level of discipline there was a technical error and Dr. Falk should have had a higher level of concern.

Dr. Haas said the standard of care for gynecology practice does not favor the laparoscopic approach over an open procedure as both menthods have equal complications.

Dr. Krishna said he favored an Advisory Letter because there was a technical error resulting in three injuries. Dr. Goldfarb agreed with Dr. Krishna. Dr. Pardo said Dr. Falk conceded to the patient's wishes rather than doing what he had been trained to do.

Sharon B. Megdal, Ph.D. stated the standard of care was met and the Board cannot fault the physician for a technical error that resulted in an expected complication. She favored dismissing the case.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patricia R.J. Griffen, Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Members voted against the motion: Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Ram R. Krishna, M.D., Douglas D. Lee, M.D. and Paul M. Petelin, Sr., M.D. The following Board Member abstained: Becky Jordan. The following Board Member was absent: Patrick N. Connell, M.D.
VOTE: 5-yay, 5-nay, 1-abstain, 0-recuse, 1-absent
MOTION FAILED.

MOTION: William R. Martin, III, M.D. moved to issue an Advisory Letter for a minor technical violation.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., and Paul M. Petelin, Sr., M.D. The following Board Members voted against the motion: Patricia R.J. Griffen, Lorraine Mackstaller, M.D. and Dona Pardo, Ph.D., R.N. The following Board Member abstained: Becky Jordan The following Board Member was absent: Patrick N. Connell, M.D.
VOTE: 7-yay, 3-nay, 1-abstain, 0-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-05-0709A	N.R.	RAJUL I. PATEL, M.D.	21576	Dismiss.

Rajul Patel, M.D. was present with counsel Mr. Stephen Myers.

Venkatesh Ramaiah, M.D. was present and spoke during the call to the public on behalf of Dr. Patel. Dr. Ramaiah said that, due to Dr. Patel's busy practice, it is difficult to have perfect medical records; however, Dr. Patel made every effort to determine the patient's diagnosis in this case and did not display a lack of judgment. Secondly, Dr. Ramaiah said the stent was indicated in this patient and Dr. Patel's care and concern for his patients is apparent.

William Wolf, M.D., Medical Consultant summarized the case for the Board. Dr. Wolf found Dr. Patel deviated from the standard of care by performing a left iliac angioplasty with stenting on NR when she had an absence of indications such as a limb threatening disease or disabling claudication. Additionally, Dr. Wolf said there was no evidence in the medical record that Dr. Patel performed a peripheral vascular examination before undertaking an angioplasty with stenting. Dr. Wolf found actual patient harm in that the patient underwent unnecessary iliac angioplasty and stent placement that may have led to occlusion of the left iliac artery ultimately necessitating an aortobifemoral bypass that otherwise would have been unnecessary.

Tim B. Hunter, M.D. led the questioning and noted Dr. Patel did not document the patient's peripheral pulses. Dr. Patel he has since begun doing this in all patients and has not delegated that duty to the nurses. Dr. Hunter noted there was an allegation that Dr. Patel did not tell the patient about her aortic aneurism. However, Dr. Patel said he did discuss this with the patient but it was not documented.

Robert P. Goldfarb, M.D. asked Dr. Wolf if he was convinced the procedure in this case was unnecessary. Dr. Wolf said, according to the poorly documented medical records, the patient did not appear to have claudication and it appeared Dr. Patel's treatment was overly aggressive and not indicated.

Dr. Patel said most patients with peripheral vascular disease do not have the classic indications of claudication. Dr. Patel said the films from this case have been reviewed by several physicians who said the patient had a significant stenosis and he performed a successful intervention. Dr. Patel said the patient did have decreased pulses in the left leg, as documented by another professional and the patient's symptoms did improve after the procedure.

Mr. Myers noted Dr. Patel had no prior Board actions and his care in this case had been reviewed by other experts who said Dr. Patel provided appropriate care. Dr. Patel has obtained training for interventional cardiology procedures in addition to his training as a vascular surgeon and in retrospect it is clear this case confirms Dr. Patel's good clinical judgment.

Dr. Hunter found that, although Dr. Patel should have recorded the patient's pulses, he has since changed his practice and now does so for each patient. Dr. Hunter found the procedure was it indicated, although aggressive, and there was room for physician disagreement in this case.

MOTION: Tim B. Hunter, M.D. moved to Dismiss the case.
SECONDED: Paul M. Petelin, Sr., M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Member was absent: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-05-0581A MD-05-0084A	B.B. AMB	THOMAS J. PETERS, M.D.	9582	Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for mismanagement for a drug seeking patient, failure to supervise a medical assistant and inadequate medical records. Two year Probation; complete 20 hours CME in pain management and prescribing within 120 days; chart reviews every six months.

Thomas Peters, M.D. was present without counsel.

Douglas D. Lee, M.D. recused himself from this case.

Mary Lamb, Dr. Peter's office manager spoke regarding their office policy for prescriptions and refills. Ms. Lamb said she was not a medical professional but has had medical experience. Ms. Lamb said when Dr. Peters is out of town, she will go over charts with him over the phone and inform him of what patients need prescriptions. Ms. Lamb said on occasion she has filled prescriptions without having Dr. Peters approve them first, but always obtains his approval when he returns to the office.

Gerald Moczynski, M.D., Medical Consultant summarized case MD-0581A for the Board. Dr. Moczynski said Dr. Peters deviated from the standard of care by failing to supervise Ms. Lamb who issued five refills to patient PB without obtaining authorization or reviewing the refills with Dr. Peters. Dr. Peters also deviated from the standard of care by not discussing the risks and benefits of chronic narcotic pain medication with the patient. The actual harm in this case was that Dr. Peters' lack of supervision of Ms. Lamb resulted in overprescribing for a patient that subsequently led to the patient's overdose and death.

Kelly Sems, M.D., Internal Medical Consultant summarized the case MD-05-0084A for the Board. In this case, Dr. Peters deviated from the standard of care by failing to recognize patient LM's drug seeking behavior, provided excessive doses of acetaminophen and did not follow the Arizona Medical Board guidelines for the treatment of chronic pain. Additionally, Dr. Peters prescribed escalating doses of narcotics without an apparent plan or monitoring of LM and did not adequately supervise his office staff that authorized refills for LM. Actual harm was noted in that LM was hospitalized several times for suicidal ideation, motor vehicle accident and drug overdose. There was potential harm in that LM was at risk for hepatic dysfunction as a result of the excessive Tylenol contained within the prescribed medication Darvocet.

Dr. Peters said his handling of pain management and the quality of his documentation has improved since these cases. Dr. Peters said for patient PB, she was successfully taken off narcotics and he was not aware of her relapse. Dr. Peters said he since monitors patient medications using flow sheets to identify problems earlier.

William R. Martin, III, M.D. led the questioning. Dr. Martin noted Dr. Peters performed a total hip replacement for PB and should not have allowed PB to fully weight bear as this causes additional injury. Dr. Peters conceded in retrospect. Dr. Martin also noted Dr. Peters did not follow the Arizona Medical Board pain management guidelines in these cases. Dr. Peters conceded to this as well.

Tim B. Hunter, M.D. asked Dr. Peters why his unlicensed staff was able to write prescriptions for his patient's medication without his knowledge at the time. Dr. Peters stated this should not have happened and does not happen anymore in his office. Dr. Peters said Ms. Lamb only gave authorization on approval of refills for prescriptions that had already been written. Sharon B. Megdal, Ph.D. noted the "refills" Dr. Peters referred to were actually a new prescription as the refills Dr. Peters prescribed had run out and the patient had requested the prescription to be re-issued.

Dr. Martin did not note any quality of care issues in the case for patient PB but stated it was bad judgment for Dr. Peters to perform two hip replacements at the same time. Dr. Martin did find a deviation with the prescribing for both patients with drug seeking behavior. Dr. Martin said in the case of PB, it ended in suicide due to the medications prescribed by Dr. Peters, and in the case of LM Dr. Peters displayed excessive prescribing and by his testimony did not follow the Board's guidelines for chronic pain management.

MOTION: William R. Martin, III, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(e)- Failing or refusing to maintain adequate records on a patient, A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public, A.R.S. §32-1401 (27)(ii) - Lack of or inappropriate direction, collaboration or direct supervision of a medical assistant or a licensed, certified or registered health care provider employed by, supervised by or assigned to the physician and A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Ram R. Krishna, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent
MOTION PASSED.

Dr. Martin said it was the standard of care for a physician to recognize drug seeking behavior in a patient and to not prescribe excessive doses of acetaminophen. Dr. Martin also stated it is the standard of care to follow the Board's Pain Management Guidelines. Dr. Martin also noted prescribing duties should not be delegated to office staff. Dr. Martin noted actual harm in the suicide of PB and potential harm acetaminophen toxicity in patient LM. Dr. Martin found it mitigating that by Dr. Peter's testimony he acknowledged he did not recognize LM's drug seeking behavior that when he realized his error in this case he began to change his office policies. Dr. Martin found Dr. Peter's prior Board history to be aggravating.

Dona Pardo, Ph.D., R.N. asked Dr. Martin if he considered recommending Dr. Peters undergo Physician Assessment and Clinical Evaluation (PACE). Dr. Martin said he felt a financial burden such as PACE was not necessary as his testimony in this case showed he had a better understanding of pain management. Sharon B. Megdal, Ph.D. recommended Dr. Peters undergo Continuing Medical Education (CME) in pain management and prescribing practices.

MOTION: William R. Martin, III, M.D. moved to draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for mismanagement for a drug seeking patient, failure to supervise a medical assistant and inadequate medical records. Two year Probation; complete 20 hours CME in pain management and prescribing within 120 days; chart reviews every six months.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Member was recused: Douglas D. Lee, M.D. The following Board Member was absent: Patrick N. Connell, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent
MOTION PASSED.

Robert P. Goldfarb, M.D. urged Dr. Peters to read the Board's Pain Management Guidelines as posted on the Arizona Medical Board website.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-05-0603A	AMB	RICKY R. ARNOLD, M.D.	25403	Issue an Advisory Letter for failure to recognize and communicate the severity of illness in this emergency room patient. This did not rise to the level of discipline.

Ricky Arnold, M.D. was present with counsel Mr. Paul Briggs.

Kelly Sems, M.D., Internal Medical Consultant summarized the case for the Board. Dr. Sems said the OMC found Dr. Arnold deviated from the standard of care because he did not order antibiotics on the floor and failed to attend to the patient's cardiac status. Dr. Arnold also deviated by failing to order an EKG or cardiac enzymes, failed to manage the patient's shock, and inappropriately triaged the patient to the general floor. There was actual harm in Dr. Arnold's delay in the diagnosis and treatment of shock, leading to the patient's death and potential harm in that any and all of the patients' organs could have been permanently damaged if death did not occur.

Dr. Arnold said the patient displayed no overt signs of sepsis syndrome at the time he saw him in the emergency department. Dr. Arnold said after his involvement with the patient, study results came back that showed antibiotics needed to be initiated.

Douglas D. Lee, M.D. led the questioning. Dr. Lee noted it was Dr. Arnold's testimony that he dictates the patient's history and physical from memory, well after seeing the patient. Dr. Lee noted Dr. Arnold was aware the patient was in the emergency room the day prior with similar or the same symptoms, however, Dr. Arnold did not review the records from the previous day. Dr. Lee noted Dr. Arnold was aware of the patient's complete blood count (CBC) result before his shift was over. Dr. Lee said it was apparent Dr. Arnold had a working diagnosis of some type of infections process. Dr. Lee also noted Dr. Arnold ordered a blood culture, showing he was concerned about a blood borne infection, but did not document that he told the oncoming physician to follow up with the patient's lab results. Dr. Lee noted the patient was then not seen for 12 hours. If Dr. Arnold had requested the oncoming physician to come in and see the patient, the patient would not have had to wait 12 hours to be seen. Dr. Arnold conceded he most likely did not ask the oncoming physician to come in to see the patient.

Lorraine Mackstaller, M.D. noted Dr. Arnold was concerned enough to write admission orders for the patient to the hospital, yet there was miscommunication between him and admitting physician as to the seriousness of the patient.

Dr. Lee noted Dr. Arnold said if presented with a similar situation in the future, he would administer a does of antibiotics in case the patient was not seen immediately by another physician.

Mr. Briggs said the patient did not present as being critically ill. Additionally, Dr. Arnold knew the patient had been seen by his primary care physician a couple of times before presenting to him, and Dr. Arnold appropriately consulted with the primary care physician and they both considered an infections etiology. Mr. Briggs said, in this case, even if antibiotics had been given 2.8 days earlier, the patient's life would not have been saved.

Dr. Lee noted Dr. Arnold did not appropriately communicate the care of this patient, did not review the patient's records from the previous presentation to the emergency room and did not have an appropriate level of concern for the patient's symptoms. Dr. Lee also noted it was not good practice to see two to three patients first and document their findings afterwards.

MOTION: Douglas D. Lee, M.D. moved to issue an Advisory Letter for failure to recognize and communicate the severity of illness in this emergency room patient. This did not rise to the level of discipline.

SECONDED: Sharon B. Megdal, Ph.D.

Paul M. Petelin, Sr., M.D. spoke against the motion stating Dr. Arnold should have recognized the red flags in this patient and disciplinary action would be more appropriate in this case. Dr. Mackstaller spoke in favor of the motion stating Dr. Arnold appropriately admitted the patient, but failed to convey all the co-morbid symptoms to the oncoming physician and the patient was not seen for 12 hours. Dr. Mackstaller agreed Dr. Arnold could have been more aggressive, but also noted the hospitalist was neglectful in not timely seeing the patient. Dr. Goldfarb found Dr. Arnold performed an improper handoff of the case. Dona Pardo, Ph.D., R.N. noted it was mitigating that the nurses involved also had responsibility in the patient's care. Dr. Petelin stated Dr. Arnold's own lack of high concern for this patient made it impossible for him to convey an urgency or higher level of concern to the hospitalist or on-coming physician.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D, R.N. The following Board Members voted against the motion: Robert P. Goldfarb, M.D., Ram R. Krishna, M.D. and Paul M. Petelin, Sr., M.D. The following Board Member was absent: Patrick N. Connell, M.D.
VOTE: 8-yay, 3-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-05-0341A MD-05-0434A MD-05-0701A MD-05-0702A MD-05-0703A MD-05-0704A MD-05-0705A MD-05-1062A	S.O. J.S. L.K. B.L. B.G. V.R. J.K. M.K.	CYNTHIA J. MODNY, M.D.	22577	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for inadequate billing and documentation and ongoing behavior issues that adversely affect patient care. One year Probation for psychotherapy and to follow the recommendations of a psychiatrist.

Cynthia Modny, M.D. was present with counsel Mr. D. Jay Ryan.

Patricia R.J. Griffen recused herself from the case.

Kelly Sems, M.D., Internal Medical Consultant summarized the case for the Board. Dr. Sems said that Dr. Modny told Board staff that she did not feel her chemical sensitivity affected her doctor-patient relationship. Eight similar patient complaints were submitted to the Board on the basis of Dr. Modny's various alleged behavior issues. However, the Chief Medical Consultant (CMC) did not find grounds for action based upon her behavioral issues, but did have concern with her inadequate medical records and inadequate billing.

Mr. Ryan stated the Board's Staff found no harm was done to the patients and the complaints arose out of personality issues. Mr. Ryan said Dr. Modny has developed a chemical sensitivity that has caused her to terminate her active practice.

MOTION: Tim B. Hunter, M.D. moved to go into Executive Session for legal advice.
SECONDED: Paul M. Petelin, Sr., M.D.

The Board went into Executive Session for legal advice at 1:39 p.m.
The Board returned to Open Session at 1:44 p.m.
No deliberations or decisions were made during Executive Session.

William R. Martin, III, M.D. led the questioning. Dr. Martin said that all of the complaints have similar themes with a couple of exceptions. Dr. Martin said he found no quality of care issues in the cases. Dr. Martin said for case MD-05-0341A the patient complained Dr. Modny kept the doors open during her examination for ventilation to help with her chemical sensitivity. Dr. Martin also noted Dr. Modny billing the patient for code 99203 and yet did not obtain a proper history or perform a proper examination of the patient in order to support the code. Dr. Modny said the patient did not require palpation and therefore a physical inspection rather than a hands-on examination was appropriate. Dr. Martin noted Dr. Modny's detailed history of the patient did not include a chief complaint, extended history of present illness, a pertinent review of systems, pertinent past history, family history, or social history that may be related to patient's problem. Dr. Martin concluded the billing code was unsupported. Dr. Modny conceded her documentation did not support the billing code.

Dr. Martin said, in his review of the eight cases, each showed similar documentation. Dr. Modny did not agree and so Dr. Martin said he would go through three other cases to prove a pattern. In case MD-05-0434A, Dr. Martin found no detailed present illness for the patient and the medical record did not describe the location, quality, severity, timing, context or any modifying conditions for the lesion. Dr. Modny conceded it was not necessary to review the medical records on the remaining cases.

Paul M. Petelin, Sr., M.D. noted there were many complaints with similar allegations in a short period of time that reflected a pattern of offending patients. Dr. Modny said she is not rude to patients, but has to discharge them if they do not comply with the restrictions she places due to her chemical sensitivity. Dr. Modny said she will no longer be practicing medicine for the rest of her life.

Mr. Ryan said he obtained the opinion of two other physicians who said her billing and documentation was appropriate. Mr. Ryan noted there had been no patient harm in any of the cases.

Dr. Martin noted Dr. Modny's medical records were inadequate because they did not contain information for continuity of care and the standard for the billing of code for 99203 was not met.

MOTION: William R. Martin, III, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(e)- Failing or refusing to maintain adequate records on a patient and A.R.S. §32-1401 (27)(u)-Charging a fee for services not rendered or dividing a professional fee for patient referrals among health care providers or health care institutions or between these providers and institutions or a contractual arrangement that has the same effect. This subdivision does not apply to payments from a medical researcher to a physician in connection with identifying and monitoring patients for a clinical trial regulated by the United States food and drug administration.
SECONDED: Paul M. Petelin, Sr., M.D.

Lorraine Mackstaller, M.D. said she did not support an inadequate records finding as Dr. Modny's notes were consistent with other dermatology records she's seen. Paul M. Petelin, Sr., M.D. spoke in favor of the motion because he felt Dr. Modny's billing constituted fraud. Ram R. Krishna, M.D. said he found the medical records to be inadequate for a plastic surgeon or general surgeon to continue care because Dr. Modny did not define the margins of the lesion or the size of the lesion.

VOTE: 7-yay, 1-nay, 2-abstain, 1-recuse, 1-absent
MOTION PASSED.

William R. Martin, III, M.D. said he believed Dr. Modny has an illness and her behavior is a manifestation of that illness. Dr. Martin noted although Dr. Modny had been through the Physician's Health Program, it did not appear she had acted on their recommendations.

MOTION: William R. Martin, III, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for inadequate billing and documentation and ongoing behavior issues that adversely affect patient care. One year Probation for psychotherapy and to follow the recommendations of a psychiatrist.
SECONDED: Ram R. Krishna, M.D.

Tim B. Hunter, M.D. spoke against the motion stating the Board should not force a physician to get help if she does not want it. Dr. Hunter recommended an Advisory Letter for inadequate records. Douglas D. Lee, M.D., spoke in favor of the motion stating, Dr. Modny had already received an Advisory Letter for inadequate medical records. Dr. Martin noted, although Dr. Modny said she would not practice again, the Board had no guarantee of that since she had not followed the recommendations from her psychiatric evaluation.

MOTION: Sharon B. Megdal, Ph.D. moved to go into Executive Session for legal advice.
SECONDED: Tim B. Hunter, M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 1-recuse, 1-absent
MOTION PASSED.

The Board went into Executive Session for legal advice at 2:47 p.m.
The Board returned to Open Session at 2:53 p.m.
No deliberations or decisions were made during Executive Session.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N. and Paul M. Petelin, Sr., M.D. The following Board Members voted against the motion: Tim B. Hunter, M.D. and Lorraine Mackstaller, M.D. The following Board Member abstained: Sharon B. Megdal, Ph.D. The following Board Member was recused: Patricia R.J. Griffen. The following Board Member was absent: Patrick N. Connell, M.D.
VOTE: 7-yay, 2-nay, 1-abstain, 1-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-05-0977A	AMB	RUBEN CALVILLO, M.D.	14238	Issue an Advisory Letter for failure to obtain the results of a prior ECG. This does not rise to the level of discipline.

Ruben Calvillo, M.D. was present with counsel Mr. Edwin M. Gaines.

Robert P. Goldfarb, M.D. said he knows Mr. Gaines but it would not affect his ability to adjudicate the case.

Roderic Huber, M.D., Medical Consultant summarized the case for the Board. A medical malpractice settlement alleged Dr. Calvillo failed to order appropriate testing when a patient presented to the emergency department with ST elevations that were suggestive of ischemic changes. Dr. Huber said Dr. Calvillo deviated from the standard of care by failing to review the pre-hospital ECG and by misinterpreting the ECG performed at 8:27 p.m. and by failing to review the patient for a cardiology consultation. As a result of Dr. Calvillo's deviations, the patient died.

Dr. Calvillo said when the patient came in the patient was pain free and he believed the patient had a gastroespohageal problem. Dr. Clavillo said, if he would have seen the ECG, he would have immediately transferred the patient to Tucson. Dr. Calvillo said he has never had a case happen to him like this before and it has been devastating. Dr. Calvillo said he has since left working in the emergency room or hospital and now does primary care medicine and consults with a cardiologist on cases frequently.

Lorraine Mackstaller, M.D. led the questioning and asked Dr. Calvillo why he did not perform a 12 point lead for a patient with chest pain. Dr. Calvillo said he did not have a justification for his error in this case. Dr. Calvillo said he had handled many such cases successfully and knows

there were many things he could have done differently and did not have an excuse. Dr. Calvillo said it could have been simply a matter of forgetting to do so in this case. Dr. Mackstaller said she could ask many questions of Dr. Calvillo but he had already shown remorse and had since made changes to try to prevent him from being in a similar situation in the future. Dr. Mackstaller said it appeared Dr. Calvillo He thought the patient had a gastroespohageal problem and simply did not think of anything else.

Mr. Gaines said this tragic death could have been possibly alleviated and, although Dr. Calvillo does not know why he missed the patient's correct diagnosis, he has taken responsibility for the death of the patient. Mr. Gaines noted it was mitigating Dr. Calvillo had not been disciplined in the 20 years he had practiced under the Board and he had been forthright, and had remediated the error.

Dr. Mackstaller found actual harm in that the patient died and noted the standard of care required him to read the pre-hospital ECG, correctly interpret the ECGs performed in the hospital and transfer the patient for a cardiology consultation. Dr. Mackstalle did not find Dr. Calvillo deviated by failing to appropriately read the second ECG in the case as the changes were hardly noticeable. Dr. Mackstaller did find Dr. Calvillo deviated from the standard of care by failing to initially evaluate the first ECG taken, therefore missing the opportunity for cardiac referral.

MOTION: Lorraine Mackstaller, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: William R. Martin, III, M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

Dr. Mackstaller noted there were many mitigating circumstances in that Dr. Calvillo had a remote record with the Board, admits his error in this case and has made changes in life to avoid being confronted with a situation like this again.

MOTION: Lorraine Mackstaller, M.D. moved to issue an Advisory Letter for failure to obtain the results of a prior ECG. This does not rise to the level of discipline.
SECONDED: Paul M. Petelin, Sr., M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Member was absent: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-05-0695A	M.T.	ROBERT L. BROOKS, M.D.	31171	Issue an Advisory Letter for failure to timely diagnose an ectopic pregnancy. This does not rise to the level of discipline.

Robert Brooks, M.D. was present with counsel, Mr. Gregory Harris.

Ingrid Haas, M.D., Medical Consultant summarized the case for the Board. Dr. Brooks deviated from the standard of care by failing to promptly evaluate and treat an ectopic pregnancy. There was actual harm in that, due to the delay in diagnosis, the patient sustained a ruptured ectopic pregnancy, laparotomy and loss of her fallopian tube. There was potential harm in that the delayed diagnosis of ectopic pregnancy put the patient at risk of significant hemorrhage and potential of hemorrhagic shock and death.

Dr. Brooks said he has not been in this situation before where an ectopic ruptured while keeping careful watch of the patient. Dr. Brooks said he believed he handled the patient appropriately because relied on a good physical exam. Dr. Brooks said he scheduled a DNC but it was delayed due to problems with the insurance.

Robert P. Goldfarb, M.D. led the questioning. Dr. Goldfarb noted the beta HCG indicated the patient had an ectopic pregnancy. Dr. Brooks said a Dilatation and Curettage (D&C) would have been appropriate to perform and he did not realize it was going to be delayed. Dr. Goldfarb noted the patient returned to Dr. Brooks six days after appearing in the emergency room and three days following the patient's second episode of pain and bleeding. Dr. Goldfarb noted Dr. Brooks should have quickly obtained a diagnosis at that point. Dr. Goldfarb said a transvaginal ultrasound would have been a modality to obtain a quick diagnosis.

Mr. Harris said Dr. Brooks had to make careful choices to protect both the patient's health and her future pregnancy options. Mr. Harris noted Dr. Brooks practiced within the standard of care as articulated by the Board's Outside Medical Consultant (OMC). Mr. Harris said Dr. Brooks now understands the systems issues with insurance companies and has become more active in his management of his patients. Mr. Harris said Dr. Brooks' practice has been made better by this experience.

Dr. Goldfarb found there was a delay in the patient's diagnosis and without such there may have been a better likelihood of success in this case.

MOTION: Robert P. Goldfarb, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Ram R. Krishna, M.D.
VOTE: 7-yay, 3-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

Dr. Pardo spoke against the motion stating both OMC's who reviewed this case had differing opinions. Dr. Goldfarb said the time delay could have been catastrophic. However, Dr. Goldfarb noted it was mitigating that as soon as Dr. Brooks found out he could not do the D&C timely, he immediately called another physician doctor and had the patient's records faxed that day. Dr. Goldfarb found this showed Dr. Brooks had good communication and attempted to obtain the proper care for the patient.

MOTION: Robert P. Goldfarb, M.D. moved to issue an Advisory Letter for failure to timely diagnose an ectopic pregnancy. This does not rise to the level of discipline.
SECONDED: Ram R. Krishna, M.D.

Dona Pardo, Ph.D., R.N. spoke against the motion and felt the case should be dismissed.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D. and Paul M. Petelin, Sr., M.D. The following Board Members voted against the motion: Becky Jordan, Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Members were absent: Patrick N. Connell, M.D. and Patricia R.J. Griffen
VOTE: 7-yay, 3-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

The meeting adjourned at 5:12 p.m.

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Timothy C. Miller, J.D., Executive Director